WORCESTER STATE UNIVERSITY

486 Chandler Street
Worcester, Massachusetts 01602
508-929-8055 Fax: 508-929-8175

Date Received: _____
(Office Use Only)

SPEECH–LANGUAGE–HEARING CENTER

Audiology—Adult Case History Form (Confidential)

Please complete this form and return to the above address. This information will help in planning an evaluation and/or treatment. Please send any speech-language-hearing reports from previous agencies with this case history form.

Personal Information

Date:_____

Name:_____ Date of Birth:_____ Age:_____ Sex:_____

Address:_____
(# Street)

_____
City State Zip Code

Home Phone:_____ Cell Phone:_____ Business Phone:_____

Email:_____ Fax:_____

Preferred method of communication: Email ☐ Telephone ☐

Are you a Worcester State University **faculty / staff / student** ? If yes, circle one.

Name of person giving information, if different from above:_____

Relationship to client:_____

Referred by:_____

Reason for referral:_____

Have you been evaluated or treated at this Center before? Yes ☐ No ☐

If yes, when and for what reason?_____

_____

Person responsible for payment of fees:_____

History

Reason for visit (primary complaint): _____

_____

Rev 2/2015

Have you ever had your hearing evaluated before? No ☐ Yes ☐

When and why? _____

Do you have concerns about your hearing? No ☐ Yes ☐

In which ear? Right ☐ Left ☐ Both ☐

When was the onset of your hearing loss?_____

Was the onset sudden ☐ gradual ☐

Does your hearing fluctuate from day to day? No ☐ Yes ☐

What was the cause of your hearing loss?_____

Please check any of the following that are true of your hearing now:

- ☐ I can hear, but I do not have a clear understanding of what I am hearing.
- ☐ I have difficulty hearing in one-on-one situations in a quiet environment.
- ☐ I have difficulty hearing in groups.
- ☐ I have difficulty hearing with background noise.
- ☐ I prefer to have the television turned louder than those around me.
- ☐ I have difficulty hearing on the telephone.

Do you presently use a hearing aid? No ☐ Yes ☐

If yes, for how long?_____

Have you ever been to an Otolaryngologist (Ear, Nose, and Throat physician)?
No ☐ Yes ☐: When and why? _____

Does anyone in your family have a hearing loss? No ☐ Yes ☐: Who?_____

Have you ever been exposed to loud sounds? (gunfire, heavy machinery, loud music, etc.) No ☐ Yes ☐

Please explain. _____

Please indicate if you have / had any of the following:

- ☐ Noise in your ears or head ☐ Pain in your ears
- ☐ Fullness or stuffiness in your ears ☐ Facial numbness or tingling
- ☐ Drainage or discharge from ears

Do you ever feel dizzy, unsteady, or off-balance (gait problems)? No ☐ Yes ☐

If yes, is your dizziness accompanied by:
- Nausea No ☐ Yes ☐
- Vomiting No ☐ Yes ☐
- Noise in ears No ☐ Yes ☐

Do you have concerns about speech and/or language issues? No ☐ Yes ☐

Please explain. _____

How would you rate your general health? Poor ☐ Fair ☐ Good ☐ Excellent ☐

Are you currently on any medication? No ☐ Yes ☐

If yes, please list: _____

Please indicate if you have ever had any of the following:

- ☐ Allergies
- ☐ Arthritis
- ☐ Chicken Pox
- ☐ Convulsions
- ☐ Diabetes
- ☐ Dizziness
- ☐ Ear aches/infections
- ☐ Fainting spells
- ☐ Frequent colds
- ☐ Frequent laryngitis
- ☐ Frequent sore throats
- ☐ Frequent upper respiratory infections
- ☐ High fever
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Otosclerosis
- ☐ Pneumonia
- ☐ Scarlet fever
- ☐ Sinus trouble
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Whooping cough
- ☐ Other

Please indicate if you have ever taken any of the following medications:

- ☐ Mycin Antibiotics (e.g. Streptomycin, Kanamycin, Neomycin, Gentamycin, Tobramycin, Amikacin, Erythromycin, Vancomycin)?
- ☐ Aspirin (or Aspirin containing products) at least 6-8 per day for extended periods of time?
- ☐ Non-steroidal anti-inflammatory drugs (Advil, Aleve, Indocin, Motrin, Naprosyn, Nuprin) at least 6-8 per day extended periods of time?
- ☐ Quinine or quinine containing products (e.g., Malaria medicine, muscle cramps, excessive intake of tonic water)?
- ☐ Intravenous Diuretics?
- ☐ Chemotherapy Agents?

If you checked any of the above medications, please elaborate: _____

Summary

Provide additional information that you believe might be helpful in the evaluation or remediation process. Attach additional pages if needed. _____

Signed:_____Date:_____

How did you hear about our services?

- ☐ Radio
- ☐ Mailing
- ☐ Alumni
- ☐ Family/Friend
- ☐ Website
- ☐ WSU posting
- ☐ Senior Presentation
- ☐ Television
- ☐ Newspaper
- ☐ Health Fair
- ☐ Higher Education Consortium of Central Massachusetts (HECCMA)
- ☐ WSU Employee
- ☐ Other:_____

Reminder

Before returning this paperwork to Worcester State University Speech-Language-Hearing Center, have you:
Completed this case history in its entirety?
Read and signed the following release forms?
• Authorization for observation, audio/DVD recording, and use of email/text messaging ☐
• Authorization for Release of Information ☐
Contacted other agencies to have them forward reports to you or directly to the Worcester State University Speech-Language-Hearing Center?

For additional information, please contact:
Ann T. Veneziano-Korzec, M.S., CCC-SLP , Director • 508-929-8055

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_____ Diagnostic Evaluation
_____ Therapy