

## Auditory Processing Disorder Case History: Adult

Name:	D.O.B:	Today's Date:
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Preferred hand: <input type="checkbox"/> Right <input type="checkbox"/> Left
Referring Physician:
Physician Address:

### HEARING HISTORY:

1. Do you have a history of ear problems?  Yes  No

Please check (✓) all that apply:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Ear infections             | <input type="checkbox"/> Earaches                         | <input type="checkbox"/> Ear canal discharge / bleeding     |
| <input type="checkbox"/> Excessive ear wax          | <input type="checkbox"/> Tubes in the ear                 | <input type="checkbox"/> Hole/perforated eardrum            |
| <input type="checkbox"/> Fluids behind the eardrum  | <input type="checkbox"/> Soreness/pain in the ear         | <input type="checkbox"/> Permanent hearing loss             |
| <input type="checkbox"/> Fluctuating hearing loss   | <input type="checkbox"/> Dizziness or Vertigo             | <input type="checkbox"/> Tinnitus (ringing in the ears)     |
| <input type="checkbox"/> Acoustic Neuromas / tumors | <input type="checkbox"/> Cholesteatoma                    | <input type="checkbox"/> Meniere's disease                  |
| <input type="checkbox"/> History of noise exposure  | <input type="checkbox"/> Otosclerosis                     | <input type="checkbox"/> Sudden or progressive hearing loss |
| <input type="checkbox"/> Collapsing ear canals      | <input type="checkbox"/> Ossicular dislocation / fixation | <input type="checkbox"/> Labyrinthitis                      |

2. Have you had an ear infection in the last 6 months?  Yes  No

If yes, when? \_\_\_\_\_

What type? \_\_\_\_\_

Was Medicine given?  Yes  No    What? \_\_\_\_\_

3. Have you been treated or evaluated by an Ear, Nose & Throat (ENT) doctor?  Yes  No

If yes, who? \_\_\_\_\_

When? \_\_\_\_\_

Was Medicine given?  Yes  No    If Yes, what? \_\_\_\_\_

4. Have you ever had ear surgery?  Yes  No

If yes, describe: \_\_\_\_\_

When? \_\_\_\_\_

5. Is there a family history of ear problems or hearing loss?  Yes  No

If yes, who? \_\_\_\_\_

What type? \_\_\_\_\_

6. Have you previously had your hearing tested by an Audiologist?  Yes  No

If yes, where? \_\_\_\_\_

When? \_\_\_\_\_

What were the results? \_\_\_\_\_

Were hearing aids recommended? Yes  No

7. Do you wear hearing aids?  Yes  No

If yes, what kind? \_\_\_\_\_

For which ear?  Right Ear  Left Ear  Both Ears

Where did you get them? \_\_\_\_\_

How old are they? \_\_\_\_\_

Any problems with them? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

## OTHER MEDICAL HISTORY:

1. Are you currently taking any medication?  Yes  No

If yes, what? \_\_\_\_\_

\_\_\_\_\_

2. Did you recently have a CT SCAN or MRI?  Yes  No

If yes, describe: \_\_\_\_\_

Please check (✓) all that apply:

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Heart disease               | <input type="checkbox"/> Diabetes                             | <input type="checkbox"/> High blood pressure      |
| <input type="checkbox"/> Stroke                      | <input type="checkbox"/> Asthma                               | <input type="checkbox"/> Meningitis               |
| <input type="checkbox"/> Mumps                       | <input type="checkbox"/> Scarlet fever                        | <input type="checkbox"/> Kidney or renal problems |
| <input type="checkbox"/> Measles                     | <input type="checkbox"/> Rubella                              | <input type="checkbox"/> Influenza                |
| <input type="checkbox"/> Infectious disease: _____   | <input type="checkbox"/> Syphilis                             | <input type="checkbox"/> Lyme disease             |
| <input type="checkbox"/> Multiple Sclerosis          | <input type="checkbox"/> Autoimmune disease                   | <input type="checkbox"/> Parkinson's              |
| <input type="checkbox"/> Head Trauma                 | <input type="checkbox"/> Numbness in the face                 | <input type="checkbox"/> Fever over 104 degrees   |
| <input type="checkbox"/> Cerebrovascular disorder    | <input type="checkbox"/> Facial nerve disorder                | <input type="checkbox"/> Herpes Zoster oticus     |
| <input type="checkbox"/> Tumors                      | <input type="checkbox"/> Congenital disorder / disease: _____ | <input type="checkbox"/> Ototoxic drug            |
| <input type="checkbox"/> Neurological disease: _____ |   |   |

**LISTENING AND UNDERSTANDING:**

1. Do you feel you have problems listening or understanding?  Yes  No

If yes, explain: \_\_\_\_\_

How long have you been aware of this problem? \_\_\_\_\_

2. Do you have any known or documented learning problems?  Yes  No

If yes, explain: \_\_\_\_\_

3. Do you have any known or documented speech or language problems?  Yes  No

If yes, explain: \_\_\_\_\_

4. Do you have any known or documented attention deficit or hyperactivity problems?  Yes  No

If yes, explain: \_\_\_\_\_

5. Do you have any known or documented psychological problems?  Yes  No

If yes, explain: \_\_\_\_\_

Please check (✓) any of the following that applies:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Extremely sensitive to loud sounds                     | <input type="checkbox"/> Cannot understand speech in noise                  | <input type="checkbox"/> Frequently misunderstands what is said                      |
| <input type="checkbox"/> Get confused in noisy place                            | <input type="checkbox"/> Forgetful  | <input type="checkbox"/> Difficulties recalling spoken or written information        |
| <input type="checkbox"/> Easily upset by new situations                         | <input type="checkbox"/> Often asks for repetition                          | <input type="checkbox"/> Difficulties following directions or instructions in series |
| <input type="checkbox"/> Difficulties following and/or understanding TV program | <input type="checkbox"/> Reverses words, numbers, or letters                | <input type="checkbox"/> Easily distracted   |
| <input type="checkbox"/> Difficulties recalling short or long term information  | <input type="checkbox"/> Give wrong or inappropriate responses to questions | <input type="checkbox"/> Uncoordinated or disorganized                               |
| <input type="checkbox"/> Does opposite of what is requested                     | <input type="checkbox"/> Prefers solitary activities                        | <input type="checkbox"/> Easily frustrated   |
| <input type="checkbox"/> Easily tired   | <input type="checkbox"/> Restless; problem concentrating                    | <input type="checkbox"/> Has anxiety   |
| <input type="checkbox"/> Difficulties with time concept                         | <input type="checkbox"/> Depressed  | <input type="checkbox"/> Irritable   |
| <input type="checkbox"/> Interprets words too literally                         | <input type="checkbox"/> Awkward / clumsy                                   | <input type="checkbox"/> Lack motivation   |
| <input type="checkbox"/> Hears better when watching speaker                     | <input type="checkbox"/> Ignores people, if engrossed                       | <input type="checkbox"/> Confused with similar sounding words                        |
| <input type="checkbox"/> Difficulties localizing sounds                         | <input type="checkbox"/> Difficulties understanding rapid speech            | <input type="checkbox"/> Miss important sounds or signal that others hear easily     |
| <input type="checkbox"/> Difficulties memorizing things                         | <input type="checkbox"/> Difficulties reading                               | <input type="checkbox"/> Difficulties writing  |