

THE SPEECH & HEARING CLINIC at
TEXAS WOMAN'S UNIVERSITY
Department of Communication Sciences & Disorders
P O Box 425737
Denton, TX 76204-5737
Phone: 940-898-2285 Fax: 940-898-2070

**SPEECH-LANGUAGE-AUDIOLOGY
CASE HISTORY FOR ADULTS**

Date: _____

Patient's name: _____ DOB: _____ Age: _____ Sex: _____
(print)

What is your reason for requesting this evaluation? _____

Who referred you to us? _____

Which of the following evaluations are you interested in?

Audio logical ____ Speech/Language ____ Both ____ Other (Explain) _____

Chief complaint:

About when did you first notice this problem?

Was it a sudden or a gradual onset?

Do you know what caused your problem? yes ____ No ____ If yes, please explain:

I. BACKGROUND INFORMATION

Address: _____ Home phone: _____
Street

_____ City State Zip

Current occupation: _____

Business name: _____

Business phone: _____

Business address:

Military service: _____
Years of service _____
Branch of service _____

Have you received any rehabilitation services? yes ___ no ___ If yes, please provide the dates and the provider's identification:

Facility or specialist

Speech reading: _____
Auditory training: _____
Speech therapy: _____
Voice therapy: _____
Psychological therapy: _____
Counseling: _____
Vocational: _____
Other: _____

Additional comments: (evaluate your success in the above programs) Why was therapy terminated?

II. MEDICAL INFORMATION

Family physician: _____ Phone: _____

Address: _____
Street

City State Zip

Are currently receiving Medicare ___yes ___no

Check disease(s) you have had, giving age and degree of severity.

Disease	Age	Mild,	Disease	Age	Mild,
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		Average or severe			Average, or severe
Allergies			Kidney		
Asthma			Measles		
Bronchitis			Meningitis		
Chicken Pox			Mumps		
Colds (frequent)			Ear Infections		
Hay fever			Pneumonia		
Heart disease			Seizures		
Influenza			Tonsillitis		

Other illnesses or physical disabilities not noted above:

Describe after effects of any illness, if any:

Have you ever been hospitalized? Yes ___ no ___ If so, when and for what reason? _____

Current medications: (including aspirin and other non-prescription drugs/herbal remedies)

Current health status: poor ___ fair ___ good ___ excellent

Do you have difficulty with balance, dizziness, fear of heights or being moved? yes ___ no ___

If yes, please describe:

Do you wear glasses? yes ___ no ___

Health of other family members: good ___ bad ___ Explain:

Family history of hearing loss? yes ___ no ___ Family history of learning disability? yes ___ no ___

Family history of speech or language difficulties? yes ___ no ___

Other pertinent family history? yes ___ no ___ If so, please explain:

III. EAR HEALTH

Do you experience ear pain? yes _____ no _____ If so, which ear?
right _____ left _____ both _____

If yes, how often?

Do you have discharge? yes _____ no _____ If so, which ear?
right _____ left _____ both _____

If yes, how often?

Do you experience sensations of fullness or pressure in you ears?
yes _____ no _____

If yes, how often?

Do you experience episodes of dizziness or imbalance? Yes ___ no ___

If yes, how often?

Do you experience unexplained episodes of nausea? Yes _____ no _____

If yes, how often?

Do you experience tinnitus (ringing in your ears)? Yes _____ no _____
Ear: right _____ left _____ both _____

If yes, describe the type: buzzing _____ hissing _____ thumping _____
ringing _____ steam _____ other: _____

(explain:)

Have you had ear surgery? Yes _____ no _____ nose surgery? Yes _____ no _____
throat surgery? Yes _____ no _____

Describe:

What is your experience with noise exposure? (prior and current) _____

Additional comments:

Do you have a hearing loss? Yes ____ no ____ If yes, continue. If no, skip to page 6, Section V.

IV. HEARING LOSS: HISTORY AND PRESENT STATUS

Chief complaint:

About when did you first notice this problem?

Was it a sudden ____ or a ____ gradual ____ onset?

Do you know what caused your hearing problem? Yes ____ no ____ If yes, please explain:

Which is your better ear? Right ____ left ____ both the same ____

Does your hearing fluctuate? Yes ____ no ____

Check the situations in which you have difficulty hearing:

____ in quiet	____ in conversation	____ in conferences
____ in noise	____ on telephone	____ radio, TV, movies
____ female voices	____ male voices	____ localization
____ other (please specify)		

Additional comments:

Have you had a previous hearing test? Yes ____ no ____ If yes, where and by whom?

Have you ever worn a hearing aid? Yes ____ no ____ If yes, which ear?
Right ____ left ____ both ____

Are you still wearing one? Yes ____ no ____ If no, please explain:

If yes, please indicate who recommended that you wear aid(s)?

Make: _____ Model: _____

Date of purchase: _____

Where purchased: _____

Number of hours worn per day: _____

Current condition of aid(s): _____
Difficulties with hearing aid(s): _____

Evaluate the service you have obtained from your hearing aid dispenser:

Additional comments about your hearing aid(s): (degree of satisfaction,
situations presenting special

problems, service problems, other)

V. EDUCATIONAL-VOCATIONAL HISTORY

What are some of your duties at your current job?

Your best performance at work is in what area?

What part of your job is particularly difficult or challenging?

What is your preferred occupation?

If you are not employed, how long have you been unemployed? _____

Are you planning to return to some type of work? Yes ___ no ___

If so, will you need special training or help? Yes ___ no ___ Explain:

Last grade attended in school:

What kind of grades did you usually get in school? Poor ___ fair ___
good ___ excellent ___

Which subjects were the most difficult?

Which subjects were the easiest?

Have you been diagnosed with any of the following? Please check all that
apply:

Speech/Language problem
Neurological Damage
Dyslexia
Mental Retardation

Attention difficulties
Learning disabilities
Emotional difficulties
Hyperactivity

What is the primary language spoken in your home?

What other languages are spoken in your home?

If English is your second language, how long have you spoken English?

Please provide any additional information which you feel will help us to understand your communication needs better?

In the space below, please give us the name and address of any facility/physician that you would like to have a copy of our findings.

Name

Street

City

State

Zip

I give my permission for the Texas Woman's University Speech & Hearing Clinic to release a copy of their findings to the above listed individuals/agencies.

Patient's signature

Date