ADULT CASE HISTORY FORM

Date: ________________________ 20___

Name: ____

Address: ____

City: ______________________________ State: ________________

Spouse's name: ____

Spouse's address: _________________________ City: ____________________________

Physician: _________________________ Address: ____________________________

Physician's Phone: ____________________ Referred by: ______________________

INSURANCE INFORMATION

Person responsible for payment: ______________________________

Employer: ____

Social Security #: ______ - ____ - ______ Date of Birth: ___/___/______

Primary Insurance: _______________________ ID or Policy #: ____________________

Other Insurance: _______________________ ID or Policy #: ____________________

HEALTH HISTORY

Accidents: Yes / No (circle one) Illnesses: Yes / No

Allergies: Yes / No Fainting: Yes / No

Head injuries: Yes / No Ear drainage: Yes / No

Fullness in the ear: Yes / No Exposed to loud noises/explosions: Yes / No

Medications and type: ____

Have you ever worked in a loud setting for an extended period of time? Yes / No

If you answered yes to any of these questions, please explain:

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