LSU Health Sciences Center

Speech-Language-Hearing Clinic*Department of Communication Disorders*School of Allied Health Professions*1900 Gravier Street 9th Floor*New Orleans, La 70112*504-568-4337

ADULT CASE HISTORY FORM

BACKGROUND INFORMATION

Patient's Name _____

Address_____

Home Phone Number _____Work No._____ Cell No._____

Birthdate _____ Age _____ Sex _____ Marital Status _____

Social Security No. _____ _____ _____ Medicaid/Medicare No. _____

Referred by _____Address_____

FINANCIALLY RESPONSIBLE PARTY

Name _____ Relationship to Patient _____

Address _____

Employer _____ Occupation_____

MEDICAL INSURANCE

Name _____Phone Number _____

Contract No._____Group No. _____

Name _____Group No. _____

Name _____Group No. _____

FAMILY INFORMATION

Patient's Occupation _____Patient's Birthplace _____

Place of Employment _____

Spouse's Name _____Spouse's Age_____

Occupation _____Place of Employment_____

List all of the patient's children:

Name Sex Age Any Problems_____

_____

_____

_____

_____

_____

Who lives in the patient's home:_____

Is English the primary language spoken in the home? _____Other languages spoken in the home _____

_____

Indicate the first language learned, if not English_____

HISTORY OF SPEECH PROBLEM

What has the patient been told is his/her main problem or medical diagnosis?_____

_____

Age of onset: _____Conditions of Onset? _____

Have any attempts been made to treat this problem? _____ If yes, list date of treatment, site of treatment, and results of treatment,

reasons for discharge. _____

_____

_____

_____

Are the symptoms constant or do they change? _____

When are they better? _____When are they worse?_____

To the patient, is this problem considered mild, moderate, or severe? _____

Does the speech/hearing problem cause difficulty in day-to-day living (including educational, social, or vocational plans)?

If yes, please explain._____

_____

_____

Do people have a difficult time understanding the patient when he/she talks to them? Explain. _____

_____

_____

What is expected from this visit? _____

_____

What questions would the patient like answered from this evaluation?_____

_____

_____

_____

_____

MEDICAL HISTORY
List the patient's personal physician _____

List serious accidents, illnesses, medical conditions, and surgeries:
Problem Date After Effects

_____

_____

_____

Indicate past (**p**) and current (**c**)illnesses

_____Allergies	_____Asthma	_____Chicken pox
_____Chronic Illness	_____Concussions	_____Convulsions, Spasms, seizures
_____Diabetes	_____ Dizziness	_____ Earaches
_____Excessive colds	_____Headaches	_____ Hearing difficulties
_____High fever	_____Laryngitis	_____Measles
_____Meningitis	_____Nausea	_____Noises in the ear
_____Oral cancer	_____Pneumonia	_____Sinus problems
_____Sore throat	_____Speech difficulties	_____Swallowing problems
_____Thyroid problems	_____Tonsillitis	_____Upper respiratory infections

Please list any other illnesses the patient has had _____
If the patient has had any convulsions, spasms, or seizures, please indicate how many and when the last one occurred.
_____

List all of the patient's physical disabilities _____

List the patient's current medications and reason for the reasons for taking them _____

_____

Is the patient in good health at this time? If not, explain _____

_____

Estimate health of other family members _____

Does the patient currently have a vision problem? _____

DESCRIPTION OF SPEECH PROBLEM (If there are no concerns about speech, skip this section)
Circle any of the following that describes the patient's voice:

Often hoarse	High-pitched	Low-pitched	Very loud
Too soft	Easily tired	Breaks in voice	Normal

Circle any of the following that describes the patient's speech:

Mispronunciations	Hesitant to speak	Stuttering	Fast rate of speech
Slow rates of speech	Normal speech	Speaks with an accent	Breathy

Does the patient experience any of the following? Circle all that apply.

Difficulty understanding others	Difficulty to get others to understand them
Difficulty finding the right word	Difficulty expressing what they want to say
Difficulty swallowing	Difficulty reading and comprehending

Has anyone looked at the patient's vocal cords and/or soft palate? If yes, what did they find? _____

_____

_____

DESCRIPTION OF HEARING PROBLEM

Does the patient believe he/she has a hearing loss? _____ If yes, was it sudden or gradual loss?_____

_____

Has the patient ever had a hearing test?_____ If yes, please list when and the results of the test._____

_____

Has the patient's hearing changed in the last six months?_____Within the last year?_____ Within the last two years _____

Does the patient's hearing seem to change from day-to-day? _____

Does the patient experience pain in their ears?_____If yes, please indicate which ear and how often _____

_____

Have the patient's ears ever drained?_____If yes, indicate which ear and how often_____

_____

Has the patient ever been exposed to loud noises? If yes, describe _____

_____

Has the patient ever worn a hearing aid?_____ If yes, is the hearing aid used now?_____

Does the patient feel like his/her hearing loss interferes with communication? Explain_____

_____

Does anyone in the family have a hearing loss? ___ yes ____ no Relationship_____

EDUCATIONAL HISTORY

What was the highest level the patient achieved in school?_____

Were his/her grades considered good, average, or poor?_____

Were any school subjects difficult for the patient?_____Specify_____

Did the patient have reading difficulty in school?_____

SOCIAL HISTORY

Please list any/all as they apply to the patient for the following:

Hobbies _____

Leisure time activities _____

Group memberships_____

Does the patient engage in hunting activities?_____

Has the patient ever been enlisted in the military?_____ If yes, when_____

OCCUPATIONAL HISTORY

How long has the patient had his/her current occupation?_____

What was his/her previous occupation?_____

Is the patient retired?_____ If yes, for how long?_____

Has the patient's speech/hearing problem caused him/her to change jobs?_____

Explain_____

Is the patient's working environment noisy?_____

OTHER (past or current)

List other professional services (including psychological, neurological, hearing, speech, etc.) received. Include name and date of service.

_____

_____

_____

Please give any other information you think would be helpful to us in working with the patient.

_____

_____

_____

Name of the person completing this form (if not the patient)_____

Relationship to patient_____