Department of Communication Disorders
Edgar R. Garrett Speech and Hearing Center
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CASE HISTORY FORM – ADULT

GENERAL INFORMATION

Name: _____ DOB: _____ ☐Male ☐Female

Physical Address, City, State, Zip: _____

Mailing Address, City, State, Zip: _____

Phone #: _____ Email Address: _____

Occupation: _____

☐Single ☐Widowed ☐Divorced ☐Married ☐Engaged

Spouse's/Partner's Name: _____ Phone #: _____

How did you hear about us?
☐Word of Mouth ☐Advertisement ☐NMSU Faculty ☐Other: _____

PHYSICIAN & BENEFIT INFORMATION

Primary Physician: _____ Phone #: _____

Are you enrolled in Medicare? ☐Yes ☐No

Do you receive Social Security Disability Insurance (SSDI)? ☐Yes ☐No

DEMOGRAPHIC INFORMATION

Children: (Include Name and Age)

_____

_____

Who lives in the home? _____

What languages do you speak? _____

Level of Education: _____

Describe the reason for evaluation: _____

_____

_____

_____

What do you think may have caused the problem? _____

_____

_____

Have you ever seen a speech language pathologist? If yes, who and when? What were their conclusions or suggestions? _____

_____

_____

Have you seen other specialists (e.g., physicians, audiologists, psychologists, neurologists)? If yes, please indicate the type of specialist, when you were seen and the specialists conclusions or suggestions. _____

_____

_____

Family history of speech, language or hearing problems in your family? If yes, please describe.

_____

_____

_____

MEDICAL HISTORY

Have you had any of the following?

☐Adenoidectomy	☐Chicken Pox	☐Draining Ear	☐Asthma	☐Dizziness
☐German Measles	☐Croup	☐Encephalitis	☐Influenza	☐Ear Infection
☐High Fever	☐Meningitis	☐Headaches	☐Measles	☐Seizures
☐Mastoiditis	☐Pneumonia	☐Tonsillitis	☐Mumps	☐Tinnitus
☐Otosclerosis	☐Sinusitis	☐Colds	☐Noise Exposure	

☐Other: _____

Do you have eating or swallowing difficulties? If yes, please describe: ☐Yes ☐No

_____

_____

List all medications you are currently taking

_____

_____

Are you having any negative reactions to your medications. If yes, please describe: ☐Yes ☐No

_____

_____

List major surgeries or hospitalizations (include dates):

_____

_____

Describe any major accidents:

_____

_____

Provide any additional information that may be helpful for evaluation:

_____

_____

_____

_____

_____

Name of person completing this form: _____