Hearing History

Name _____ Date_____

Are you aware of any hearing loss? _____ When did it start? _____

Do you experience any of the following? (please check)

___Ringing in the ears or tinnitus
___ Ear pain
___ Drainage from the ear
___ Popping or fullness in the ear
___ Dizziness or Vertigo

Have you had a hearing test before? ____yes ___ no When? _____

Where? _____

Have you been seen by an Ear, Nose and Throat Doctor? ___ yes ___ no Who? _____

Have you ever had any ear surgery? ____yes ___ no Which ear? ____Right ear ___Left ear

When?_____ What type of surgery? _____

Does anyone in your family have hearing loss? ___ yes ___ no Who? _____

Noise Exposure

Have you ever worked in Noise? ___ yes ___ no Ear Protection ___ yes ___ no

If yes, Where? _____ How long? _____

Do you have any noisy hobbies? _____ Ear Protection ___ yes ___ no

Communication and Hearing Aids

Number of person in household? _____

Do you have difficulty hearing any of the following? (please check)

___ conversation ___ in groups ___in background noise ____ television

___ other (please explain) _____

Do you currently use a hearing aid? ___ yes ___ no If yes, which ear? ____ Right ear ____ Left ear

Are you satisfied with its performance? _____