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? ______________________________________________________________