Hearing History

Name _____ Date_____

Date of Birth _____

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

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

Ringing in the ears or tinnitus	☐ YES	NO ☐	Popping or Fullness in Ear	☐ YES	NO ☐
Ear pain	☐ YES	NO ☐	Dizziness or Vertigo	☐ YES	NO ☐
Drainage from the ear	☐ YES	NO ☐	Falling	☐ YES	NO ☐
Head Injury	☐ YES	NO ☐			

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? _____

Use of Tobacco products in past 24 months? ☐ YES ☐ NO Type of product _____

Current Medication including prescription medications, OTC, Herbal supplements including dosage and frequency.
(if you have a written list, we can take a copy)

_____

_____

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? _____