Hearing Advancement Center

HEARING HEALTH HISTORY

Original Date: ____________________ Dates Revised: ____________________

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Full Name: ____ Date of Birth: ____________________

Last First M.I.

Have you ever had any of the following?

- ☐ Exposure to Noise
- ☐ Ringing in Ears/Tinnitus
- ☐ Ear Infections
- ☐ Ear Surgery
- ☐ Head Injury
- ☐ Fluctuating Hearing
- ☐ Family History of Hearing Loss
- ☐ Punctured Eardrum
- ☐ Pressure in Ears
- ☐ Cancer
- ☐ Sudden Hearing Loss
- ☐ Diabetes
- ☐ Dizziness
- ☐ History of Smoking or Secondhand Smoke

Previous or referring doctor: ______________________________ Date of last physical exam: ____________________

Have you ever had a hearing test? ☐ Yes ☐ No If yes, when? ______________________________

Where? ______________________________

Do you wear hearing aids now? ☐ Yes ☐ No If yes, what kind? ____________________

When did you get them? ______________________________

How do you believe you hear? ☐ Good ☐ Fair ☐ Poor

Does anyone else think you have a hearing problem? ☐ Yes ☐ No If yes, who? ____________________

Is there anything else you would like us to know about your hearing? ______________________________

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If you believe you have a hearing loss, in what situations do you have difficulty? ______________________________

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What medications are you taking now (excluding vitamins)?

Medications	Dosage	Frequency