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Patient Name: ____ Date of Birth: ____ /____/______

Companion name: ____________________________ Relationship to patient: _________________

Medical History:

Do you have pain/discomfort in your ear(s)? Yes: ____ No: ____
Do you have any drainage in your ear(s)? Yes: ____ No: ____
Have you had a sudden or rapid loss of hearing in the past 90 days? Yes: ____ No: ____
Do you have ringing or other noises in your ear(s)? Yes: ____ No: ____
Do you have acute or recurring dizziness or vertigo? Yes: ____ No: ____
Do you have a significant history of noise exposure? Yes: ____ No: ____

Have you seen your physician regarding any of the above? If so, when?_______________________
____

Does anyone in your family have hearing loss? If so, who? _________________________________
____

Have you ever had ear surgery? Yes: ______ No: ______ If yes, which ear?______________________
Please list any major surgeries and illnesses (past 10 years) _________________________________
Current Medications (i.e. blood thinners?): ____
Allergies to any medications, plastics, etc? ____
Any history of ear infections? ____

Do you or did you ever have any of the follow diseases?

____ Mumps	____ Scarlet Fever	_____ Meningitis
____ Measles	____ Meniere's Disease	_____ Ear Infections
____ Diabetes	____ Cancer	

Hearing History:

When did you first notice difficulty hearing? ____

Have you had your hearing tested before? Yes: ________ No: _________
When: __________________ Results: ____

In which ear is your hearing the worst? Right: ________ Left: ________ Same: ________

	Yes	Sometimes	No
Do you have difficulty hearing the TV or radio?	______	______	______
Does your hearing cause frustration with family members?	______	______	______
Does your hearing cause you to visit family and friends less often?	______	______	______
Do you have difficulty hearing in a noisy environment? (i.e. restaurant)	______	______	______
Do you feel left out in group conversations because of your hearing?	______	______	______
Does your hearing cause you to avoid groups of people?	______	______	______
Do you have difficulty when someone speaks in a whisper?	______	______	______
Does your hearing cause embarrassment when meeting new people?	______	______	______
Do you feel your hearing limits or hampers your personal and social life?	______	______	______
Do you feel handicapped by a hearing problem?	______	______	______

If hearing loss is diagnosed, are you ready for help? Yes: ______ No: ________

Please list the top three listening situations where you would like to hear better (i.e. Family gatherings, TV):

____

Please complete the following if you currently have a hearing aid:

How often do you wear your hearing aid(s)? ____
How old is/are your hearing aid(s)? ____
Style of hearing aid(s): ________________________ Brand: _______________________ Cost: _________
Do you wear hearing aids in both ears? Yes: ______ No: ______
Where were you fit with the hearing aid(s)?____
When wearing your hearing aid(s), do you have difficulty understanding in crowds? Yes: ____ No: ____

Do your hearing aids make your ears sore? Yes: ______ No: ______
Do your hearing aids whistle? Yes: ______ No: ______
Do you repair your hearing aids often? Yes: ______ No: ______
What is the greatest problem with your hearing aids? ______________________________________
____

On a scale of 1 to 10, rate your satisfaction level with your hearing aids (1=Poor, 10=Excellent):______

Thank you for completing this questionnaire. The information will help us provide guidance for your hearing needs.