

Hearing History Questionnaire

Date: _____

Name: _____ Date of Birth: _____ Age: _____

Referred by: _____

Reason for requesting evaluation: _____

Do you have a hearing problem? Yes _____ No _____

If so, how long have you noticed it? _____

What is the cause of your hearing problem? _____

Have you had your hearing tested before? Yes _____ No _____

If so, when and what were the results? _____

Does anyone else in your family have a hearing loss? Yes _____ No _____

If so, who? _____

Have you ever seen a medical physician about your ears? Yes _____ No _____

Have you ever had any of the following?

Ear, head, or neck surgery? Yes _____ No _____

Ear Pain? Yes _____ No _____ Ear Drainage? Yes _____ No _____

Ear Infections? Yes _____ No _____ Dizziness? Yes _____ No _____

Ringing in the Ears? Yes _____ No _____

Tolerance problems to loud sounds? Yes _____ No _____

Have you ever been exposed to loud noise? Yes _____ No _____

If yes, please describe: _____

Please describe any medical problems you may have including heart, high blood pressure, diabetes, etc.

What medications are you on? _____

Do you currently own a hearing aid? Yes _____ No _____