Hearing Health Questionnaire

Date: _____

Background Information

Name: _____ Date of Birth: _____ Age: _____

What is the reason or purpose of today's visit? _____

Who encouraged you to have your hearing tested? _____

What are you hoping to achieve as a result of this visit? _____

Symptoms

Have you been having trouble hearing recently**? YES / NO.** If yes, when did it begin? _____ Years ago, or, _____ Months ago.
Do you currently wear hearing aids? **YES / NO.** If yes, when did you purchase them? _____

Do you have any of the following? (PLEASE CIRCLE ALL THAT APPLY):

Acute or recurring dizziness	Sudden or recent hearing loss	Ear drainage	Ear pain	Punctured eardrum
Ear pressure or fullness	Ears popping	Diabetes	Skin problems	Allergies

Have you ever seen a physician concerning an ear problem? **YES / NO**. If Yes, how long ago? ____Years ago. What was the nature of the problem? _____. Was surgery performed? **YES / NO.**

Do you have tinnitus (ringing or noise in ears or head)? **YES / NO**. If yes, for how long? _____.
Is it (please circle): **CONSTANT / INTERMITTENT / EQUAL IN BOTH EARS / MORE IN ONE EAR / ONLY IN ONE EAR**

Family History

Have any of the following blood relatives had ***any degree*** of hearing difficulty? (PLEASE CIRCLE ALL THAT APPLY):

Mother	Mother's mother	Mother's father	Mother's sibling(s)	Sister
Father	Father's mother	Father's father	Father's sibling(s)	Brother

Does your spouse or partner have hearing difficulty? **YES / NO.** Does your child(ren) have hearing difficulty? **YES / NO.**

Have any of the above mentioned individuals had hearing aids? **YES / NO.**

Have any blood relatives have permanent hearing loss beginning in childhood? **YES / NO.** Ear surgeries? **YES / NO.**

Noise Exposure

Have you had noise exposure from? (PLEASE CIRCLE ALL THAT APPLY):

Work noise	Military	Factory	Truck driving	Wood working	Races
Farming	Landscaping	Loud music	Shooting	Fireworks	Other: _____

Medical History

Do you have a history of any of the following? (PLEASE CIRCLE ALL THAT APPLY): Ear infections | Middle ear fluid | Fluctuating hearing levels | Swimmer' ear | Eardrum perforation | Head injury | Ear tubes | Skin cancer on ears | High blood pressure | high cholesterol (taking cholesterol meds **Y / N**) | Cancer | Chemotherapy | Ototoxic drugs | Heart disease | heart attack | **taking blood thinners** | Stroke | TIA or mini-stroke | Artery or vascular disease | diabetic neuropathy | wound healing difficult Pacemaker | Genetic condition | Vision problem not corrected by lenses | Other: _____

Please provide a list of current medications including dose, frequency, and route (oral or injection):

_____

_____