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Patient name: _____ Date of Birth: ____ / ____ / ____

Preferred name or nickname: _____

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? _____

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 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):

1. _____ 2. _____ 3. _____

Please complete the following questions only if you 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.