

Adult Hearing Health History

Name: _____ Date of Birth: _____

What is the reason for your visit? _____

Medical History:

Yes No Have you ever seen a doctor who specializes in the ear?
If yes, name of doctor and date of last visit: _____

Yes No Have you ever had any type of ear surgery?
If yes, when and what type of surgery: _____

Yes No Have you ever had your hearing tested?
If yes, when, where, and results: _____

Yes No Do you have any other chronic medical conditions
If yes, explain: _____

Yes No Do you take any medicine every day?
If yes, what: _____

Yes No Do you have diabetes?

Yes No Do you take any blood thinners? (ex. Coumadin, heparin, warfarin)

About Your Hearing: Do you experience any of the following? (without aids)

Yes No Do you have trouble hearing conversations in quiet?

Yes No Do you have trouble hearing conversations in noisy situations or crowds?

Yes No Do you have trouble hearing on the telephone?

Yes No Do you hear people speaking but have difficulty understanding the words?

Yes No Do you have trouble hearing the television?

Yes No Have you ever worked in a loud workplace?

If yes, when and how many years: _____

Yes No Do participate in any loud activities (ex. hunting, woodworking, lawnmowing, etc.)

Yes No Do you use hearing protection at work or during these loud activities?

Yes No Do you hear ringing or buzzing sounds in your ears (tinnitus)?

If yes, which ear(s): _____

Years _____ How long have you had difficulty hearing?

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

If yes, who? _____

Yes No Do you now or have you ever worn a hearing aid?

Which ear(s): Right Left Both

Year obtained: _____ Where obtained: _____

(OVER)

