Adult Hearing Health History

Name: ___________________________ Date of Birth: ______________ Gender: M  F

Employer: ___________________________ Occupation: ___________________________

Primary Care Physician: ________________________________________________

What is the reason for your visit (primary concern)? ____________________________

How did you hear about us: □ Television   □ Radio □ Phone Book □ Internet (Search Engine)
□ Internet (Social Media) □ Mailer □ Family/Friend □ Physician □ Other

If other, please explain: ________________________________________________

Hearing History:

Yes  No  Do you feel you have a hearing loss?  If YES, is one ear worse?  Right  Left  No Difference

Has your hearing loss occurred gradually or very suddenly?  Gradual  Sudden

When did you first notice your hearing loss? ________________________________

Yes  No  Have you ever had your hearing tested?  When and Results: ________________________________

Yes  No  Have you ever worked in a loud place or participated in loud activities?  Explain: __________

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

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

If yes, which ear(s):  Right  Left  Both  If yes, does it bother you?  Yes  No

Is the tinnitus constant or occasional?  Constant  Occasional

When did your tinnitus begin? ________________________________

What does your tinnitus sound like? ________________________________

Yes  No  Does anyone else in your family have difficulty hearing?  If yes, who? ________________________________

Medical History:

Yes  No  Do you have a history of ear infections or ear surgery?

If yes, explain: ________________________________

Yes  No  Have you ever seen a doctor for an ear-related issue?

If yes, name of doctor and date of visit: ________________________________

Yes  No  Pain in your ears?  If yes, which ear(s):  Right  Left  Both

Yes  No  Drainage from your ears?  If yes, which ear(s):  Right  Left  Both

Yes  No  Dizziness or imbalance?  If yes, is it:  Constant  Occasional

When did it begin and please describe? ________________________________

Yes  No  Do you have any chronic medical conditions?

If yes, list: ________________________________

(Please Complete Back of Form)  5/15/2019
**Do you have any allergies (ex. Latex, Acrylic, dyes)?**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
</table>

**Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months?**

- If yes, how often have you used a tobacco product in the past 24 months? ____________
- If yes, what type(s) of products have you used?

**Please list all your medications, vitamins, etc (If you have this written down, we will copy it for you)**

<table>
<thead>
<tr>
<th>Name (please write legibly)</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Route (mouth, injection, etc.)</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Your Hearing Needs:** If possible, please review this with someone who lives with you or communicates with you on a frequent basis.

What motivated you to set the appointment for your hearing test? ____________________________

What is your hearing aid experience?

- [ ] I have a hearing aid and use it regularly in my:  
  - [ ] Right ear  
  - [ ] Left ear  
  - [ ] Both ears

- [ ] I have inquired about hearing aids at another office but did not purchase at the time.
- [ ] I have a hearing aid, but don’t use it or only use it occasionally.
- [ ] I have never used a hearing aid.
- [ ] I have tried a hearing aid but returned it.

Please list the top 3 situations you would most like to hear better. Be as specific as possible.

1. __________________________________________

2. __________________________________________

3. __________________________________________

Please rank your most important consideration regarding hearing aids with 1 as most and 4 as least important.

- [ ] Hearing aid size and the ability of others not to see the hearing aids
- [ ] Improved ability to hear and understand speech
- [ ] Improved ability to understand speech in noisy situations (e.g. restaurants, parties, etc.)
- [ ] Cost of the hearing aid system

On a scale of 1 to 10, how ready are you to get help for your hearing difficulty?

<table>
<thead>
<tr>
<th>Not At All Ready</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>Very Ready</th>
<th>10</th>
</tr>
</thead>
</table>

**Signature: ____________________________ Date: ____________________________

Please bring this completed form to your appointment.