Hearing Questionnaire

Patient Name:_____ Date of Birth:_____

Primary Physician's Name_____

Purpose of today's visit *(circle one or both)*: Hearing Test Hearing Aid Evaluation

Do you or have you had any of the following: *(circle all that apply)*

HEARING LOSS, EAR PAIN, DRAINAGE, FULLNESS, DIZZINESS/VERTIGO, EARDRUM PERFORATION, EAR SURGERY, ITCHY EARS, FAMILY HISTORY OF HEARING LOSS, HISTORY OF NOISE EXPOSURE, DIABETES, STROKE, CANCER, SCARLET FEVER, MUMPS, MENINGITIS

Is your hearing better in one ear? YES NO Which ear?_____

Do you have tinnitus / ringing in the ears? YES NO Which ear?_____

Is the tinnitus (*circle one)* CONSTANT INTERMITTENT

Sudden / rapid hearing loss within the past 90 days? YES NO

Do you wear hearing aids? YES NO

Which ear? RIGHT LEFT BOTH

Do you wear them consistently? YES NO

How old are they? _____

Are you happy with the benefits your hearing aids provide? YES NO

If you could change / improve something about your hearing aids what would you change?

Signature_____ Date_____