Hearing Health History

Name:_____ Date :_____

Reason for visit? _____

Do you have difficulty hearing? ___Yes ___No If Yes (Circle) Right Ear, Left Ear or Both?

Describe your difficulty hearing_____

Was the onset of your hearing loss sudden or gradual? _____

Do you have any ringing or noises in your ears? ___Yes ___No
If Yes (Circle) Right Ear, Left Ear or Both? If yes, please describe it: _____
_____

Have you had any dizziness in the last 90 days? ___Yes ___No
If yes, please describe it: _____
_____

Do you have a history of noise exposure, either work-related or recreational? ___Yes ___No
If yes, please explain: _____
_____

Is there a history of hearing loss in your immediate family? ___Yes ___No
If yes, please explain: _____

Do you have a history of any of the following?

Pain in your ears	___Yes	___No	Smoking	___Yes	___No
Ear Infections	___Yes	___No	Diabetes	___Yes	___No
Ear Drainage	___Yes	___No	Pacemaker	___Yes	___No
Ear Surgery	___Yes	___No	Head Trauma	___Yes	___No

If yes, please explain: _____
_____
_____

Have you ever worn hearing devices/aids? ___Yes ___No ; If yes, how long? _____

Please describe your experience with hearing aids: _____
_____

List ALL medications you are taking (including over-the-counter medicines and vitamins), with the dosage and route of administration: _____
_____
_____
_____

List ALL surgeries you have had: _____
_____
_____
_____