Hearing History

The Hearing Center
Hear Better, Live Better

Name _____ Date _____

What kind of hearing problems do you have? (Describe specific situations of difficulty regarding your hearing)

_____

_____

When did your hearing loss begin? _____

What do you think caused your hearing loss? _____

_____

Do you hear better in one ear? _____ If so, which ear? _____

Was it a sudden hearing loss or a gradual decrease in hearing? Has your hearing worsened recently? _____

_____

Do you have problems hearing over the telephone? ◯ Yes ◯ No

Which ear do you use on the telephone? ◯ Right ◯ Left

Have you had ear infections _____, and/or drainage _____? If so, which ear? _____

Have you ever received surgery for an ear problem? Describe (include approximate dates):

_____

_____

Have you ever had a skull fracture or concussion? Explain:

_____

_____

Do you have "ringing" or other noises (Tinnitus) in your ears or your head? ◯ Yes ◯ No

If yes, which ear(s)? ◯ Right ◯ Left ◯ Both When is it present? ◯ Constantly ◯ Occasionally ◯ Unsure

When did it begin? _____ How long does it last? _____

Describe what it sounds like to you:

_____

How much does it bother you? (1 = slight, 5 = most severe): ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Do you experience dizziness such as spinning, falling, floating, etc.? ◯ Yes ◯ No

If yes, describe (how often, what causes it, any other associated problems): _____

Have you been around noise that may have affected your hearing? ◯ Yes ◯ No

Have you been around noise that may have affected your hearing? ◯ Yes ◯ No

If yes, describe:

Military (artillery, jets, tanks, etc.): _____ Years _____

Work (noisy factory, construction, etc.): _____ Years _____

Recreation (hunting, chain saws, etc.): _____ Years _____

Did/do you use hearing protection consistently? ◯ Yes ◯ No

What kind of hearing protection do you use? ◯ Earplugs ◯ Earmuffs ◯ Both

Is there a history of hearing loss in your family? ◯ Yes ◯ No

If yes, who in your family and what caused their hearing loss? _____

_____

Do family members or friends complain about your hearing? _____

Have you had a hearing test before? ◯ Yes ◯ No

Where? _____ When? _____

If known, what were the results? _____

_____

Have you ever worn a hearing aid(s)? ◯ Yes ◯ No

If yes, what make are/were your hearing aids? _____

Where obtained: _____ When obtained: _____ Effectiveness: _____

Comments: _____

Have you ever been given drugs that you were told might affect your hearing or balance? ◯ Yes ◯ No

If yes, what were you given? _____

Check any that you have or had:

◯ Meningitis	◯ Cancer	◯ Macular Degeneration	◯ HIV AIDS
◯ Diabetes	◯ Malaria	◯ Chemotherapy	◯ Vision Problems
◯ Asthma/Lung	◯ Scarlet Fever	◯ High Blood Pressure	◯ Dexterity Difficulties
◯ Cleft Palate	◯ Mumps	◯ Heart Problems	
◯ Head Injuries	◯ Allergies	◯ Hepatitis A B C D	

Do you currently smoke tobacco? _____

Comments:

_____

Patient or Guardian Signature _____ Date _____