PATIENT HISTORY

PATIENT_____ DATE_____

MEDICAL HISTORY:

Have you been examined by a doctor in the past 6 months?	Yes No
Will this be your first hearing test?	Yes No
Have you had ear surgery?	Yes No

Do you have any of the following?:

Deformity of the ear	Yes No
Sudden or rapid hearing loss in the past 90 days	Yes No
Acute or recurring dizziness	Yes No
Has the hearing in one ear worsened in the past 90 days?	Yes No
Do you ever have ear pain?	Yes No
Have you ever found it necessary to have a doctor remove wax from your ears?	Yes No
In which ear is your hearing the worst?	Left Right Same

HEARING HISTORY:

Have you noticed that people seem to mumble?	Yes No
Do you find yourself asking people to repeat what they have said?	Yes No
Do you sometimes hear words but don't always understand them?	Yes No
Do you find it difficult to hear in noisy places?	Yes No
Have you been told that you speak loudly?	Yes No
Do you find it difficult to understand speech when your back is to the speaker?	Yes No
Do others complain that you set the TV too loud?	Yes No
Have you been told on occasion that you have missed the ringing of a telephone?	Yes No
Do you find it difficult to hear when using the telephone?	Yes No
Do you avoid social events because of your hearing difficulty?	Yes No
How many years have you experienced hearing difficulty?	_____
How did your hearing loss develop?	Suddenly Gradually
Do you know the cause of your hearing loss?	Yes No
Do you have a hearing aid?	Yes No
	Right Left

HEARING AID USER:

(While wearing your hearing aid)

I can hear but I have difficulty understanding	Yes No
I have difficulty understanding when two or more are talking	Yes No
I have difficulty understanding when in a crowd	Yes No
I have difficulty understanding at a distance	Yes No
I have difficulty knowing from which direction sounds are coming	Yes No
I have difficulty while using the telephone	Yes No
My own voice sounds hollow and unnatural	Yes No
Words often run together	Yes No
My hearing aid(s) don't make the sounds loud enough	Yes No
Some sounds are too loud	Yes No
My hearing aid(s) make sounds tinny	Yes No
My hearing aid(s)whistles	Yes No
My hearing aid(s)makes my ear sore	Yes No