NORTHGATE HEARING SERVICES
We listen so you can hear

HEARING HEALTH HISTORY

Name: _____ Date: _____

1. Have you ever had a hearing test before? ☐Yes ☐No
   If "Yes", When? _____ Where? _____
   If "Yes", were you told that you had a hearing loss at that time? ☐Yes ☐No
2. Check how you believe you hear: ☐Good ☐ Fair ☐ Poor
3. Does anyone else think you have a hearing problem? ☐Yes ☐ No
4. If you think you have a hearing loss, how long have you noticed it? _____

5. If you believe you have a hearing loss, in what situations do you have difficulty?
   1. _____
   2. _____
   3. _____

6. Have you had or have any of the following: (please check if yes)

☐ Exposure to noise? If yes, when? _____ What sort of noise? _____
☐ Ringing in ears/tinnitus? Explain:_____
☐ Ear infections? If yes, when? _____
☐ Ear surgery? If yes, When? _____What kind? _____
☐ Head Injury? ☐ Punctured eardrum ☐ Sudden hearing loss?
☐ Fluctuating hearing? ☐ Pressure or fullness in ear? ☐ Dizziness?
☐ Diabetes? ☐ Cancer ☐ _____

7. What medications are you taking now? (Excluding vitamins) _____
_____
_____

8. Do you have any blood relatives with hearing loss? ☐Yes ☐No

9. Have you ever worn hearing aids? ☐Yes ☐ No

10. Do you wear hearing aids now? ☐ Yes ☐ No

When and where did you get your hearing aids? _____

What problems are you having with your hearing aids? _____
_____
_____

13. Is there anything else you would like us to know about your hearing?
_____
_____
_____
_____
_____