HEARING HISTORY

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 medicine or 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 _____
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 _____
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:

Do you take medications regularly? Yes _____ No _____

If yes, what medications do you take? _____

Have you ever been given drugs that you were told might affect your hearing or balance? _____
If yes, what were you given? _____

Check any that you have or had:

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

Anything else you would like us to know? _____

COMMENTS:

Patient or Guardian Signature: _____ Date: _____

Examiner: _____ Date: _____