

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 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: _____

Do you take medications regularly? Yes No

If yes, what medications do you take? **Please fill out attached medications form.** _____

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:

- | | | | |
|-------------------------------------|-------------------------------------|--|--|
| <input type="radio"/> Meningitis | <input type="radio"/> Cancer | <input type="radio"/> Macular Degeneration | <input type="radio"/> HIV AIDS |
| <input type="radio"/> Diabetes | <input type="radio"/> Malaria | <input type="radio"/> Chemotherapy | <input type="radio"/> Vision Problems |
| <input type="radio"/> Asthma/Lung | <input type="radio"/> Scarlet Fever | <input type="radio"/> High Blood Pressure | <input type="radio"/> Dexterity Difficulties |
| <input type="radio"/> Cleft Palate | <input type="radio"/> Mumps | <input type="radio"/> Heart Problems | |
| <input type="radio"/> Head Injuries | <input type="radio"/> Allergies | <input type="radio"/> Hepatitis A B C D | |

Do you currently smoke tobacco? _____

Comments:

Patient or Guardian Signature _____ Date _____