



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 feel you have a hearing problem? Yes No Who? _____
- 4. If you think you have a hearing loss, how long have you noticed it? _____
- 5. If you think 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 loud noise 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 that started at middle age or earlier?
 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?

Office use: _____