Hearing HealthCare, Inc. Questionnaire

Patient Name:_____ **Date:**_____

What difficulties are you having with your ears and/or hearing? (please circle all that apply)

Pain Fullness/Pressure Ear Infections Excessive Ear Wax

Drainage Sudden Hearing Loss Gradual Hearing Loss Tinnitus/Ringing in the Ears

Dizziness/Vertigo Familial History of Hearing Loss Noise Exposure

Please explain all circled:_____

_____

Have you had surgery on your ears? Yes No **If yes, please explain.** _____

_____

Are you on any medications? Yes No **If yes, please list:** _____

_____

Have you seen a physician about your ears in the past 6 months: Yes No

If yes, please explain:_____

When was your last hearing evaluation?_____

What was the result?_____

HEARING HISTORY:

If you are having hearing and/or understanding difficulties, in what situations?

Please circle all that apply:

Noisy situation (restaurants/parties/in car) Quiet situations Groups

Phone Conversations One on One Conversations Religious Services Music

Please explain all circled._____

_____

Do you currently wear hearing aids or use assistive hearing device? Yes No

If so, what brand and model?_____

If you could improve upon your current hearing aid(s) performance, what would you change?

_____

If you are not wearing hearing aid(s) now, have you ever tried them? Yes No

If yes, which ear? Left Right Both **How long did you wear the hearing aid(s)?** _____

Why did you stop wearing them?_____