

## Hearing History Evaluation Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Reason for Today's Visit: \_\_\_\_\_

### CURRENT SYMPTOMS

Have you experienced any of the following conditions? *If yes*, briefly explain.

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Chronic Ear Infections  | <input type="checkbox"/> Heart Condition         | <input type="checkbox"/> Depression        |
| <input type="checkbox"/> Ménière's Disease       | <input type="checkbox"/> Kidney Disease          | <input type="checkbox"/> Sound Sensitivity |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Nervousness/Anxiety     | <input type="checkbox"/> Diabetes          |
| <input type="checkbox"/> Cancer/Cancer Treatment | <input type="checkbox"/> One-Sided Hearing Loss  | <input type="checkbox"/> Head Trauma       |
| <input type="checkbox"/> Anemia/Blood Disorders  | <input type="checkbox"/> Sinus Problems          | <input type="checkbox"/> Liver Disease     |
| <input type="checkbox"/> Alzheimer's/Dementia    | <input type="checkbox"/> Stroke                  | <input type="checkbox"/> Dizziness         |
| <input type="checkbox"/> Deformity of the Ears   | <input type="checkbox"/> Genetic Disorders       |  |
| <input type="checkbox"/> Visual Problems         | <input type="checkbox"/> Allergies (List): _____ |  |

Comments: \_\_\_\_\_

Are you currently a smoker?  Yes  No

*If yes*, how many years? \_\_\_\_\_

Have you fallen at all in the last 24 months?  Yes  No

*If yes*, how many times? \_\_\_\_\_

Do you think you have a hearing problem?  Yes  No

*If yes*, how long have you noticed the problem? \_\_\_\_\_

Was the onset:  Sudden  Gradual

Which ear is poorer?  Left  Right  Unsure

Does your hearing remain:  Constant  Fluctuate

Has your hearing become worse since you first noticed the problem?  Yes  No  Unsure

Do you currently have difficulty hearing or understanding the following?

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Watching TV         | <input type="checkbox"/> At the Movies            | <input type="checkbox"/> Sirens            |
| <input type="checkbox"/> Restaurants         | <input type="checkbox"/> Fire/Smoke Detector      | <input type="checkbox"/> Doorbell/Knocking |
| <input type="checkbox"/> Crowds              | <input type="checkbox"/> One-on-One Conversations | <input type="checkbox"/> Telephone Ring    |
| <input type="checkbox"/> Using the Telephone | <input type="checkbox"/> Worship Service          | <input type="checkbox"/> Alarm Clock       |

Other (List): \_\_\_\_\_

How important is it for you to improve how you hear, understand or communicate with others **right now?**  
(Not at All Important)  0  1  2  3  4  5  6  7  8  9  10 (Extremely Important)

Have you had your hearing tested before?  Yes  No

*If yes, when and where?* \_\_\_\_\_

Have you had any drainage from the ear within the past 90 days?  Yes  No

Have you experienced any dizziness, vertigo or balance problems?  Yes  No

Have you had any pain/discomfort in your ears within the past 90 days?  Yes  No

Do you have any noises or ringing in your ears?  Yes  No

*If yes, which ear?*  Left  Right  Both

*If yes, is it:*  Constant  Intermittent

*If yes, when did you first notice it?* \_\_\_\_\_

Have you ever been exposed to loud noises (via employment, the military, recreation, etc.)?  Yes  No

*If yes, describe the type of noise:* \_\_\_\_\_

Have you seen or had ear surgery by an ENT?  Yes  No

*If yes, please explain:* \_\_\_\_\_

Have you seen your primary care doctor in the past six months?  Yes  No

*If yes, provide their name:* \_\_\_\_\_

Have you ever seen a doctor for wax removal?  Yes  No

*If yes, when?* \_\_\_\_\_

Does anyone in your family have hearing loss (e.g., parents, siblings, etc.)?  Yes  No

Have you ever worn hearing instruments?  Yes  No

*If yes, how would you rate your experience with your hearing aids?*

(Unsatisfactory)  0  1  2  3  4  5  6  7  8  9  10 (Great)

Select all that apply:

- I have been thinking that I might need hearing aids.
- I have started to seek information about hearing aids.
- I am ready to wear hearing aids if they are recommended.
- I currently wear hearing aids.

Comments or questions for the audiologist: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have reviewed the above information and confirm that it is true and accurate. All information obtained will remain completely confidential.

Signature: \_\_\_\_\_