Hearing History Questionnaire

Date: _____

Name: _____ Date of Birth: _____ Age: _____
Referred by: _____

Reason for requesting evaluation: _____

Do you have a hearing problem? Yes _____ No _____
If so, how long have you noticed it? _____

What is the cause of your hearing problem? _____

Have you had your hearing tested before? Yes _____ No _____
If so, when and what were the results? _____

Does anyone else in your family have a hearing loss? Yes _____ No _____
If so, who? _____

Have you ever seen a medical physician about your ears? Yes _____ No _____

Have you ever had any of the following?

Ear, head, or neck surgery?	Yes _____	No _____
Ear Pain?	Yes _____	No _____
Ear Drainage?	Yes _____	No _____
Ear Infections?	Yes _____	No _____
Dizziness?	Yes _____	No _____
Ringing in the Ears?	Yes _____	No _____
Tolerance problems to loud sounds?	Yes _____	No _____

Have you ever been exposed to loud noise? Yes _____ No _____

If yes, please describe: _____
Please describe any medical problems you may have including heart, high blood pressure, diabetes, etc:
_____
_____

What medications are you on? _____

Do you currently own a hearing aid? Yes _____ No _____