Name ____________________________

Occupation ________________________

Referred by _________________________

Date ______________________________

Reason for referral __________________

1. When did you first notice the problem? _______________________________________

2. Do you know the reason for this problem? ______________________________________

3. Has it become worse? If so, explain __________________________________________

4. Do you hear better in one ear? If so, explain _____________________________________

5. Any history of hearing loss in your family? If so, explain ____________________________

6. Do you wear a hearing aid? Yes or No
   If yes, how long? ____________________________________________________________
   Is it satisfactory? Please explain _______________________________________________

7. Have you ever been exposed to loud noise, recently or in the past? Yes or No (please check (v) all that apply)
   □ Firearms   □ Factory work   □ Military equipment   □ Power tools
   □ Music      □ Farm equipment □ Explosions      □ Heavy equipment
   □ Motorcycles/recreational vehicles □ other _________________________________

8. Please check (v) if you have experienced any of the following:
   □ Excessive ear wax      □ Ear drainage/bleeding    □ Swimmer’s Ear
   □ Ear pressure/fullness □ Popping sensation in the ear □ Ear pain
   □ Fluctuating hearing loss □ Fluid behind the eardrum □ Dizziness/Vertigo
   □ Sensitivity to loud noises □ Tinnitus (head noises)

9. Please check (v) if you have been diagnosed with any of the following:
   □ Otosclerosis      □ Cholesteatoma         □ Sudden hearing loss
   □ Labyrinthitis    □ Meniere’s disease    □ Barotrauma
   □ Permanent hearing loss □ Ossicular dislocation/fixation □ Acoustic neuroma
   □ Bell’s palsy

10. Please list your current prescriptions, including vitamins, supplements, herbal remedies or over the counter:

<table>
<thead>
<tr>
<th>Medication</th>
<th>Reason</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
</tr>
</tbody>
</table>

*If needed, please list additional medications on a separate piece of paper.
Name __________________________________________

11. Have you ever used tobacco products of any kind?  Yes or No

12. How many alcoholic drinks per week do you consume? ________________________________

13. Please check (V) if you have experienced any of the following

- Heart disease
- Stroke/TIA
- Diabetes
- High blood pressure
- Hypothyroidism
- Asthma
- Mental illness
- Depression or anxiety
- Migraines
- Mumps
- Meningitis
- Measles
- Scarlet fever
- HIV/AIDS
- Tuberculosis
- Visual Problems
- Hepatitis A, B or C
- Liver Problems
- Kidney or renal problems
- Chronic sinus infections
- Environmental allergies
- Cancer
- Radiation/chemotherapy
- Long term IV antibiotics
- Head trauma
- Loss of consciousness
- Exposure to chemicals/solvents

14. Please read through each listening situation and evaluate how well you hear. Also determine how important it is for you to hear in that situation.

<table>
<thead>
<tr>
<th>Hearing Quality</th>
<th>Importance to you</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor</td>
<td>Good</td>
</tr>
<tr>
<td>Quiet (one on one conversation) 1</td>
<td>1 2 3 4 5</td>
</tr>
<tr>
<td>Television.................. 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Music....................... 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Leisure activities........ 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Restaurants............... 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Church........................ 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Meeting/groups........... 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Work place................ 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Telephone................... 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Car.......................... 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Male voice.................. 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Female voice............... 1</td>
<td>2 3 4 5</td>
</tr>
<tr>
<td>Child’s voice............... 1</td>
<td>2 3 4 5</td>
</tr>
</tbody>
</table>

15. What do you hope to gain from this testing? __________________________________________