Vegas Valley Hearing

Hearing Aids ● Hearing Protection ● Audiology

HEARING HEALTH INFORMATION

Do you have difficulty hearing? _____Yes_____No____Right ____Left

For how long?_____

Which ear is worse? ____Right _____Left

Do you have a history of ear infections? _____Yes_____No_____Right_____Left

Have you ever had ear surgery? ____Yes____No____Right____Left

Please briefly explain_____

_____

Do you have a family history of hearing loss? ____Yes____No Please explain_____

_____

Do you have ringing/noises in your ears? ____Yes____No_____Right____Left

For how long?_____

Do you ever feel dizzy? _____Yes_____No Please explain_____

_____

Do you have a history of noise exposure? ____Yes____No

Have you ever had a head injury? ____Yes____No

Any major medical problems? ____Yes____No Please briefly explain_____

_____

Do you have a Pacemaker? ____Yes____No

Do you use tobacco products? ____Yes____No

Comments_____

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