MEDICAL / AUDIOLOGICAL HISTORY

Will this be the first time you've had a hearing test? YES NO
If no, what year were you last tested in? _____

Have you ever had ear surgery? YES NO
If yes, when?_____ which ear?_____ what procedure?_____

Do you have noises or ringing in your ears (tinnitus)? YES NO

Do you have a history of chronic ear infections either as a child or adult? YES NO

Do you have a family history of hearing loss? YES NO

Have you been exposed to a lot of noise in your life? YES NO
If yes, please explain_____

Have had any trauma to the head? YES NO
If yes, please explain_____

In which ear do you hear better? (please circle) RIGHT LEFT NOT SURE

What do you believe caused your hearing problems?_____

Do you wear hearing aids? YES NO If yes, which ear? RIGHT LEFT BOTH

Are you having any problems with your hearing aids? If yes, please explain_____

What brought you in to have your hearing tested today? _____

Have you had or currently have any of the following? (please circle)

High Blood Pressure Cancer Heart Disease Stroke Diabetes Meningitis