Family Hearing Care

Hearing Questionnaire

Patient Name ____________________________ DOB ______________________

What is your primary complaint today? ______________________________

When did the problem begin? Gradual Sudden

Has your hearing been tested before? Yes No

If yes, When? ______________________

Have you ever had ear surgery before? Yes No

If yes, When? __________Which ear? ___________Procedure? _______________________

Ear pain?	Yes	No
Ear Drainage?	Yes	No
Ear or Head noises (tinnitus)?	Yes	No
Sinus problems/allergies?	Yes	No
Head Trauma?	Yes	No
Dizziness	Yes	No
History of noise exposure?	Yes	No

Do you have difficulty hearing or understanding speech:

During normal conversation?	Yes	No
In noisy places such as restaurants?	Yes	No
In church or auditoriums?	Yes	No
On the telephone?	Yes	No
Television?	Yes	No
Do other complain about your hearing?	Yes	No
Do you currently wear hearing aids?	Yes	No

Year purchased? ____________________

Please list any current medical conditions:

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