Patient Hearing Health Interview

Patient Name: _____ Date: _____

1. Were you referred by? Physician Newspaper Radio Direct Mail Television Website Friend
2. Have you had your hearing tested before? _____ Where? _____Date:_____
3. If you currently wear hearing aids do they satisfy all of your listening needs? Yes No
4. Circle the listening areas that present the most difficulty for you. Conversation TV Social settings Phone

   Please describe other_____

. 5. Please list all your medications, vitamins and supplements._____ _____

   _____

6. From which ear do you hear better? Right Left No Difference

Y N Do you experience pain, fullness, or drainage in or around your ears? Right Left Both

Y N Do you experience ringing in your ears or head? Right Left Both

Y N Do you experience dizziness, nausea, or loss of balance?

Y N Have you ever had surgery on your ears? Right Left Both Type of Procedure?_____

Y N Have you experienced any sudden change in your hearing in the past 90 days?

Y N Have you ever been exposed to extremely loud noise? Describe_____

Y N Does anyone in your family have hearing loss?

Y N Have you ever had a heart attack or stroke?

Y N Are you diabetic?

Y N Do you think you might benefit from wearing hearing aids?

To be answered by the specialist:

Visible congenital or traumatic deformity of the ear? _____

Audiometric air bone gaps equal to or greater than 15db at 5, 1 & 2 kHz._____

Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? _____

_____

NOTES: _____