Hearing DOCTORS of Ohio
7251 Engle Rd. Suite 110
Middleburg Hts., OH 44130
Tel: 440-234-5515

Name: _____
Address: _____City:_____Zip:_____
Telephone Number – Home: _____ Work: _____
Date of Birth: _____Occupation:_____
Referred By: _____Email Address_____
Insurance Information_____
Family Physician_____

Background Information:
Have you ever had your hearing tested before? YES NO When? _____
Where? _____By:_____
Recommendations: _____
When did you first notice you had a hearing problem? _____
Which do you think is the better ear? LEFT RIGHT
What do you think caused your hearing problem? _____
Has your hearing gradually decreased or did it become worse all of a sudden? _____
Does your hearing seem to fluctuate? _____
Do you have noises or ringing in your ears? YES NO Dizzy spells? YES NO
Please describe: _____
How do sudden loud noises affect you? _____
Do other members of your family have hearing problems? _____
Have you had recent ear aches? Ear infections? Ear Discharge? Surgery? _____
When? _____
Treatment? _____
Physician: _____Address:_____
Do you or have you ever worked in a noisy place? _____
Are you exposed to noise in your pastimes or hobbies? _____
Are you a diabetic? YES NO Please list any other medical conditions: _____
_____
Please list current medications: _____
_____

Communication Problems:
Where do you have trouble hearing? Radio/T.V._____ Groups: _____ Job: _____ Large rooms: _____
Other: _____
Do you hear, but have difficulty understanding? _____
Do you hear some people better than others? Describe: _____
Do you use the telephone? _____ Can you hear it ring? _____ Which ear do you use? _____
Do you avoid social situations you enjoy because of your hearing problem? _____
Do you hear car horns, sirens, or other warning signals when they occur? _____

Amplification History:
Have you ever worn hearing aids? YES NO (If YES, complete the following).
Brand/Model: _____ Style: _____
Ear(s) fitted: _____ When Purchased: _____
Performance of present/past instrument(s):_____
_____