ChEARS HEARING CENTER
AUDIOLOGY & HEARING AID SERVICES

Adult Hearing Health History

Name of patient:_____Date of birth: _____

Today's date: _____

Hearing health history - please check all that apply:

Have you had your hearing tested before? Yes☐ No☐ If yes, where? _____

☐Perceived hearing loss – Right ☐ Left☐ Both☐ Duration: _____

☐Ear surgery. Please specify_____

☐Ear infections

☐Vertigo/imbalance

☐Pain in the ears - Right ☐ Left ☐ Both ☐

☐Fullness in the ears – Right ☐ Left ☐ Both ☐

☐Sudden hearing loss – Right ☐ Left ☐ Both ☐

☐Noise exposure. Please specify_____

☐Family history of hearing loss

☐Other. Please specify_____

Tinnitus

Do you notice tinnitus (noise in the ears)? Right ☐ Left ☐ Both ☐

Constant ☐ Periodic ☐ How long have you noticed tinnitus? _____

Hearing difficulties - please check all that apply:

☐TV/Radio ☐One on one conversations ☐Small/large groups

☐Restaurants ☐Telephone ☐Car ☐Place of worship ☐Meetings

☐Other. Please specify: _____

Have hearing aids been recommended by a professional? Yes ☐ No ☐

Do you currently use hearing aids? Yes ☐ No☐

If yes, what hearing aids are you using? _____

Full time use ☐ Part time use ☐

Are you satisfied with your current hearing aids? Yes ☐ No ☐

If no, please specify: _____

Other medical history – please check all that apply:

☐Cancer

☐Stroke

☐Meningitis

☐History of high fever

☐Changes in cognitive function/memory

☐Head injury. Please specify: _____

☐Genetic disorder. Please specify: _____

☐Shingles

☐Headaches/migraines

_____

Signature