

Name: _____ DOB: _____ Age: _____ Family Doctor: _____

Have you seen your family doctor in the last 6 months? Y N

Would you like a report sent to your family doctor? Y N

How is your overall health? Good Fair Poor

Do you have a history of: (Circle all that apply)

Diabetes	Stroke	Head Injury	Heart Issues	High Blood Pressure
Arthritis	Meningitis	Measles/Mumps	Vision Problems	
Dizziness	Depression	Cancer	Fall History	Recent Dental Work

Medications:	<i>Name</i>	<i>Dosage</i>	<i>Reason</i>	<i>Name</i>	<i>Dosage</i>	<i>Reason</i>
	_____			_____		
	_____			_____		
	_____			_____		

Ear and Hearing History:

Ear Pain	Y	N	Ear Pressure/Fullness	Y	N	Ear Drainage	Y	N
Ear Surgery	Y	N	Type and date of surgery:	_____				
Ringing	Y	N	How long and in which ear:	_____				

Family history of hearing loss? Y N Who? _____

Have you ever been exposed to loud noises? Y N Occupational or Recreational

Do you currently wear ear protection when you are around loud noises? Y N

How long have you had trouble hearing? _____	When do you have trouble hearing? _____
Have you ever avoided a situation because of your hearing problem? Y N	Do you feel like you can hear sounds but cannot always understand the words? Y N
Do you often ask people to repeat? Y N	Do others complain the TV is too loud? Y N
Do you have trouble hearing on the phone? Y N	
How many times during the week are you in noisy situations such as restaurants and social activities? _____	
What do you like to do in your spare time? _____	

Have you ever worn hearing aids? Y N Right Left Both When did you get them? _____

How are they working for you? _____

Would you wear a hearing aid(s) if it helped you? _____

Are you concerned that someone may see your hearing aids? Y N