



ADULT HEARING HISTORY FORM

PATIENT NAME: _____ DATE: _____

HEARING HISTORY:

Do you feel that you have a hearing problem? YES NO If so, for how long? _____

Do you notice hearing loss worse in one ear? YES NO If yes, which ear? RIGHT LEFT

Was the onset gradual or sudden? GRADUAL SUDDEN

What do you feel caused the hearing problem? _____

Have you ever been exposed to loud noises at work or in your hobbies (e.g., guns, power tools, tractors, loud music, motorcycles, etc.)? YES NO Explain: _____

Have you seen a physician for your hearing loss? YES NO If yes, physician name: _____

Have you ever had any surgery on your ears? YES NO Explain: _____

Do you have any dizziness or imbalance? YES NO Explain: _____

Do you have a history of ear infections? YES NO Explain: _____

Do you have any ringing in your ears? YES NO Explain: _____

Do you have pain in your ears? YES NO Explain: _____

Do you have any drainage from your ears? YES NO Explain: _____

Do you have an ear deformity? YES NO Explain: _____

Does anyone in your family have hearing loss? YES NO If yes, relation to you: _____

HEARING AID HISTORY (if applicable):

Have you ever worn a hearing aid? YES NO When did you first start wearing aid(s)? _____

When did you purchase your current aid(s)? _____ Have the aid(s) been satisfactory? YES NO

MEDICAL HISTORY:

How is your general overall medical health: EXCELLENT GOOD FAIR POOR

Do you have diabetes? YES NO Explain: _____

Have you ever had any radiation or chemotherapy? YES NO Explain: _____

Do you have an autoimmune disease? YES NO Explain: _____

Have you ever had any head trauma? YES NO Explain: _____

List any chronic illnesses: _____

List all current medications or provide a list: _____