

Patient Name: _____

1. Chief complaint: Hearing Loss (Right ear/ Left ear/ Both) Tinnitus/Ringing Dizziness Difficulty hearing (in Quiet in Noise)

2. How long have you noticed this difficulty? _____

3. Do you think your hearing is changing? Yes No (Gradual Sudden)

5. Have you ever been exposed to loud noise, either recently or in the past? Yes No

If so, please mark all that apply:

- Farm Machinery Music Hunting/Shooting Factory Noise Power Tools Military Jet Engines Other:

6. Do you have any of the following symptoms? Deformity of the ear Drainage of the ear Sudden or rapid loss within the past 90 days Acute or chronic dizziness/Imbalance Tinnitus(ringing) Ear pain

7. Have you ever had your hearing tested? Yes No If so, when was your last test? _____

8. Have you ever had surgery that may have affected your hearing? Yes No Type? _____

9. Who is your primary physician? _____

11. Have you ever had an ear infection? Yes No (If yes, as a child as an adult)

12. Do you take any prescription medications on a regular basis? Please list:

Medication: _____ For: _____
Medication: _____ For: _____
Medication: _____ For: _____

13. Please check any of the following that you currently have or have had in the past:

- Arthritis Heart Trouble Measles Parkinson's
 Asthma Hepatitis Meningitis Scarlet Fever
 Bell's Palsy High Blood Pressure Mumps Sinusitis
 Diabetes HIV Neurological Stroke/TIA
 Head Injury Malaria Symptoms Visual Trouble-Loss/Sight

14. Is there a history of hearing loss in your family? Yes No If so, who? _____

15. Is there a close friend/family member whom you are concerned about their hearing health?
If so, please tell us who this person is: _____

16. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:

___ Improved hearing in quiet ___ Improved hearing in noise
___ Cosmetic appearance ___ Expense

16. If you are currently using a hearing aid, or have in the past, please answer the following:

Which ear is/was aided? Right Left Both
How long have you used a hearing aid? _____

17. Please list three hobbies or interests.

HEARING DIFFICULTY QUESTIONNAIRE

Listening Situations	Hearing Quality					Importance to You		
	Poor			Normal		Not	Somewhat	Very
Quiet (one on one conversation)	1	2	3	4	5	1	2	3
Television	1	2	3	4	5	1	2	3
Leisure Activities	1	2	3	4	5	1	2	3
Restaurants	1	2	3	4	5	1	2	3
Church	1	2	3	4	5	1	2	3
Meetings/Groups	1	2	3	4	5	1	2	3
Work Place	1	2	3	4	5	1	2	3
Telephone	1	2	3	4	5	1	2	3
Car	1	2	3	4	5	1	2	3
Male Voice	1	2	3	4	5	1	2	3
Female Voice	1	2	3	4	5	1	2	3
Child's Voice	1	2	3	4	5	1	2	3
Other (please indicate)	1	2	3	4	5	1	2	3