

Name:		Date:
What is the primary reason for your visit? _____		
HEARING HISTORY		
	NO	YES
Do you have reduced hearing?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears When did it begin? _____ Did your reduced hearing occur gradually or suddenly? ☐ Gradually ☐ Suddenly What sort of difficulties is your reduced hearing causing for you? _____
Do you have ear pain?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears When did it begin? _____
AURAL (EAR) HEALTH		
	NO	YES
Do you have ear fullness or feel plugged?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears
Have you had ear surgery?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears Reason for surgery: _____
Do you get frequent ear infections?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears When was your last ear infection? _____

TINNITUS (EAR RINGING)		
	NO	YES
Do you get ringing in your ears?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears Describe what it sounds like: _____ When did it begin? _____
Does it pulsate like a heartbeat?	☐	☐
Does it make it hard for you to fall asleep?	☐	☐
Does it wake you up from sleep?	☐	☐
Do you find it difficult to tolerate everyday sounds?	☐	☐
BALANCE		
	NO	YES
Do you get dizziness/vertigo?	☐	☐ How frequently? _____ How long does it last? _____ What triggers it? _____ What effect does it have on your daily function? _____
Do you feel afraid you might fall?	☐	☐
NOISE EXPOSURE		
	NO	YES
Have you been exposed to loud noise either at work or elsewhere?	☐	☐ What kind of noise? _____

MEDICAL HISTORY		
	NO	YES
Do you have a heart condition?	☐	☐ Explain: _____
Do you have high blood pressure?	☐	☐
Are you diabetic?	☐	☐
Do you have any allergies?	☐	☐ What are you allergic to? _____
Do you take prescription medication?	☐	☐ For what? Please explain: _____
Do you smoke?	☐	☐
Do you consume alcohol?	☐	☐ How many glasses per week? _____
FAMILY HISTORY		
	NO	YES
Did anyone in your family develop hearing loss before the age of 65 years?	☐	☐ Relation to you? _____

AMPLIFICATION		
	NO	YES
Have hearing aids ever been recommended for you?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears
Do you currently wear hearing aids?	☐	☐ What do you like most about your hearing aids? Explain: _____ _____ What do you like least about your hearing aids? Explain: _____ _____ _____
If hearing aids can improve your hearing and you are not already wearing hearing aids, are you motivated to try them?	☐	☐
Reasons for (not) wanting hearing aids:		
HEARING NEEDS What are your top 3 most important hearing needs? 1. _____ 2. _____ 3. _____		