Adult Hearing Health History

Date ________ File# ________

Patient Name____DOB_______________Male ☐ Female ☐

I. Reasons for today's visit (please circle)

Hearing Loss   Hearing Aid / Implant   Tinnitus   Balance   Ear Pain / Fullness

II. Please explain

Hearing Loss Both ears ( ) Right only ( ) Left only ( ) N/A ( ) Right-handed / Left-handed / Ambidexterity

When did it occur?________________Causes?____

Onset (sudden, fluctuating, gradual)_________________________________Which ear is worse?_______________

When was your last hearing test and where?____

Hearing Aids   Both ears ( )   Right only ( )   Left only ( )   N/A ( )

When did you start to wear your hearing aids? ____

When and where did you get your current devices? ____

Make / Model / Style ____Year ________

Problems with your current device: ____

Implant   Both ears ( )   Right only ( )   Left only ( )   N/A ( )

When and where did you get your implant? ____

Make Advanced Bionics / Cochlear / MED-EL / Model __________________Style ___CI / Hybrid___Year ________

Problems with your device: ____

Tinnitus (ringing in the ears) Both ears ( ) Right only ( ) Left only ( ) N/A ( ) Which ear is worse? R / L

Describe the sounds__________________________________When did it first occur?_____Constant or periodic?

Is the sound bothersome and distressing? Please describe ____

Unsteadiness / Dizziness / Vertigo   **Occurring with:** Ear fullness - Nausea - Tinnitus - Hearing Loss

Describe the symptom____When did it first occur?____________

Constant or periodic?________________________________If periodic, how long does it last?________________

Treatment _____________________________Did you have bad falls in the past year and how many? __________

Ear Infections / Middle Ear Problems   Both ears ( )   Right only ( )   Left only ( )   N/A ( )

Previous treatment or surgery____

III. Have you ever had any of the following physical or medical conditions?

Vision loss ☐   Eye surgery ☐   Arthritis ☐   High blood pressure ☐   Stroke or TIA ☐   Migraines ☐

Meningitis ☐ Kidney disease ☐ Diabetes ☐ Heart defect ☐ Pacemaker ☐ G. I. System ☐ Respiratory ☐

Head injury / unconsciousness ☐ _______________ Difficulty in reading comprehension ☐ Psychological ☐

Depression ☐ Anxiety ☐ Dementia / Alzheimer's ☐ Mumps ☐ Scarlet fever ☐ Measles ☐

Sleep apnea & CPAP ☐ Wearing oxygen tank ☐ Genetic disorder ☐ ________________________________

Pain and where ☐ ____________________________ Allergies ☐ ____

Cancer and treatment (chemo, radiation, or surgery) ☐ ____

IV. Please list all medications that you are currently taking (a copy of your meds)

1.______________________ 2.______________________ 3.______________________ 4.________________

5.______________________ 6.______________________ 7.______________________ 8.________________

Alcohol ( ) Smoke or have ever used before ( ) and when did you quit ______ Street Drugs ( ) __________

V. Family history (direct relations, paternal and maternal sides of family members)

Hearing Loss ______________________________________ Dementia __________________________________

VI. Noise exposure history

Military (Yes / No) USAR / MC / AF / NY / NG from ________ to ______ Specialty _________ Combat (Yes / No)

What did you do for living for most your adult life for how many years? ________________________________

When in high noise areas, I use hearing protection: 0% (Never) 25% 50% 70% 75% 100% (Always)

Type of hearing protection used: Ear plugs / Ear muffs (Brand & Model) _______________________________

Industrial Noises - Working equipment - Chain saw - Firearms - Loud music - Motorcycle - Other Noises

VII. Your listening needs

Conversation in quiet and in noise ☐ Group meetings (classes, church) ☐ Watching TV or movies ☐ Job ☐

Phone (iPhone, Android, Smart, Flip, Land-line) ☐ Playing musical instrument ___________________________

Outdoors (hiking, biking, camping, hunting, fishing, kayaking, golfing, skiing) ☐ Relationships with others ☐

VIII. Hearing loss / tinnitus affects your daily functions and activities

Often asking people to repeat themselves (Y / N) Hearing speech but missing words or conversations (Y / N)

Trouble hearing in noisy places and group (Y / N) Difficulty locating the sound source (Y / N)

Trouble understanding TV dialogues (Y / N) Trouble having phone conversations (Y / N)

Relationships with significant others (Y / N) Missing natural sounds (birds, crickets, etc.) (Y / N)

Loud sounds bothersome and distressing (Y / N) Trouble hearing phone ringing, alarm or doorbell (Y / N)

Daily activities and communications (Y / N) Job performance (Y / N) Outdoor activities (Y / N)

Having a fear of falling (Y / N) Reading lips (Y / N) Forgetful (Y / N)

Feeling tired at the end of the day (Y / N) Social engagement (Y / N) Quality of life (Y / N)