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:

Name	*Dosage*	*Reason*	*Name*	*Dosage*	*Reason*
_____			_____		
_____			_____		
_____			_____		

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