Hearing Health History - Adult

New Patient

Name_____ Date _____

General Health

Reason for today's appointment _____

_____

Are you being treated for any of the following? *(check all that apply)*

☐ high blood pressure ☐ diabetes ☐ thyroid problems

Please list any serious illnesses within the past 10 years

_____

Please list all major surgeries within the past 10 years

_____

Please list your current medications

_____

Please check below if you have allergies

☐ latex ☐ plastics ☐ skin allergies _____ *(please describe)*

☐ medications _____ *(please list)*

Are you right or left handed? ..... ☐ Right ..... ☐ Left

Do you wear glasses? ..... ☐ Yes ..... ☐ No

Do you have physical limitations in your hands or arms? ..... ☐ Yes ..... ☐ No

Hearing History

Have you ever had a hearing test? ..... ☐ Yes ..... ☐ No

If yes, when and by whom? _____

What were the recommendations? _____

_____

Does your hearing fluctuate? ..... ☐ Yes ..... ☐ No

Do you experience ringing or noises in your ears? ..... ☐ Yes ..... ☐ No

Which ear is your hearing the poorest? ..... ☐ Right ..... ☐ Left

Which ear do you use on the telephone? ..... ☐ Right ..... ☐ Left

Do you have any difficulties understanding? ..... ☐ Yes ..... ☐ No

Have you used hearing help such as an amplified or speaker telephone? ..... ☐ Yes ..... ☐ No

Other assistive listening devices? ..... ☐ Yes ..... ☐ No

Do you have a history of excessive cerumen (ear wax) accumulation? ..... ☐ Yes ..... ☐ No

Medical Conditions *(Please check all that apply)*

☐ Sudden or progressive hearing loss in the last 90 days

☐ Family history of hearing loss

☐ History of ear infections ☐ In childhood ☐ As adult

☐ Ear Drainage within the last 90 days

☐ Ear Pain or discomfort

☐ Noise exposure

☐ Dizziness or unsteadiness. If yes, is it accompanied by ☐ vomiting ☐ nausea ☐ ear noises

☐ Deformity of the ear (visual, congenital or traumatic)

If yes, describe _____

Have you been treated by a physician for your hearing or ear problems? ..... ☐ Yes ..... ☐ No

If yes, When _____

Physician's name _____

Rate How Often You Experience The Situations Below	Always	Occasionally	Seldom	Never
I ask people to frequently repeat				
I have difficulty following a conversation involving more than 2 people				
People sound like they are mumbling or are muffled				
I have difficulty hearing in restaurants				
I have difficulty hearing women's and children's voices				
People complain that I turn the TV or radio up too loud				
My family or friends say I answer or respond inappropriately in conversations				
I feel tired or stressed when listening for long periods of time				
I get annoyed with family or friends because they don't speak so they can be heard				
I shy away from meeting new people because I may not be able to hear them				
I avoid social situations that I once enjoyed because of difficulty hearing				

Rate Your Ability To Hear In These Situations	Poor	Fair	Good	NA
Quiet Room *(1 to 2 People)*				
Television				
Music				
Restaurants				
Church				
Meetings/Lectures				
Work Place				
Telephone Conversation				
Car				
Meal Times (at home)				
Groups (4 to 6 people)				
City Street				
Large Social Gathering				
Radio				
Shopping				

Excerpted from Pickert in *Counseling for Hearing Aid Fittings* (edited by Sweetow, Singular Press, 1999)

I would most like to hear better in these situations:

1. _____
2. _____
3. _____

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