COMPLAINT:

Do you have problems hearing? Y N
How long? _______________ Which ear? Right___Left___Both___

On a scale of 1 to 10, with 1 being “no problem” and 10 being “intolerable” –
How would you rate your hearing problem _______________

Have you had a hearing test in the past five years? Y N

Do your family or friends complain about your hearing? Y N

Do your family or friends tell you keep the TV volume too high? Y N

Do you hear noises (tinnitus) in your ears or in your head? Y N
Which ear? Right___Left___Both___
How often? Constantly___Occasionally___Unsure___

Do you have: *Dizziness___Ear pain___Headaches___Discharge from your ears___ (Check all that apply)

Have you ever worn a hearing aid? Y N
Which ear? Right___Left___Both___ How long?_________

*IF YOU ARE HERE FOR DIZZINESS PLEASE NOTIFY THE RECEPTIONIST

HISTORY:

Does anyone in your family, including cousins, have hearing loss? Y N

Have you ever had a skull fracture or concussion? Y N

Have you ever had any ear surgery? Y N
Which ear? Right___Left___Both___

Have you ever had any ear infections? Y N
Which ear? Right___Left___Both___

Have you ever been exposed regularly to loud noises? Y N
If yes, where? _______________ How long? _______________

Do you take any medications regularly? Y N
If yes, for what conditions? ____________________________________________________

Have you ever been given drugs that you were told might affect your hearing or balance? Y N
What were they? ____________________________________________________

Check the illnesses you have had:
Meningitis___ Malaria___ Mumps___ Scarlet Fever___ Diabetes___
Heart Trouble___ High Blood Pressure___ Asthma___ Lung Trouble___

How did you hear about us? ____________________________________________________