

Hearing Questionnaire

Name _____ Birth Date _____

	Yes	No
Is this your first hearing test?	<input style="width: 50px; height: 20px;" type="checkbox"/>	<input style="width: 50px; height: 20px;" type="checkbox"/>

If no, what year were you tested? _____ What were the results? _____

History

1. Have you ever had ear surgery?
 If yes when? _____ which ear? _____ procedure? _____
2. Do you have noises, buzzing or ringing in your ears?
3. Did you have chronic ear infections as a child or adult?
4. Have you had any ear pain?
5. Do you have sinus or allergy problems?
6. Do you have any dizziness?
7. Have you had any trauma to the head?
8. Have you been exposed to a lot of noise in your life
9. Do you have a family history of hearing loss?

Hearing History

1. Do you hear people speaking but have difficulty understanding their words?
2. Do you have difficulty hearing in background noise (restaurants, church, etc)
3. Do you feel people mumble or slur their words?
4. Do you have to ask people to repeat words or phrases?
5. Do you prefer the TV or radio louder than others?
6. Do you have difficulty understanding conversation in a group of people?
7. Have you ever avoided social occasions or family gatherings where
 listening may be difficult for you?
8. Do you frequently nod your head "yes" in agreement when you are not sure
 what someone said?
9. Do others ever raise their voices or move closer to help you hear more clearly?
10. Do you hear some people better than others?
11. Do you hear out of one ear better than the other ear
1. How long have you had difficulty hearing and understanding? _____
2. In what two situations would you most like to hear and understand?
 a. _____
 b. _____
3. Have you ever worn hearing aids?