

# Valley Vision & Hearing Associates

Nancy Smart MS, CCCA

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## Ear/Hearing History Questionnaire

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Primary care practitioner: \_\_\_\_\_ Referred by: \_\_\_\_\_

Reason for today's assessment: \_\_\_\_\_

In what situations do you have the greatest difficulty hearing? \_\_\_\_\_

Have you ever had a hearing test in a soundproof booth? Y / N

### Please circle if you have had any of the following:

Ear infections	Tinnitus (noise or ringing in your ears)
Ear pain	Balance problems
Ear Surgeries	Meningitis
Drainage from your ears not related to cerumen	High fever requiring hospitalization
Sudden change in hearing in the last 90 days	General anesthetic in the past 4 - 5 years
Intravenous antibiotics	

### Please circle if you are being treated for any of the following:

High blood pressure	Heart disease
Stroke	Diabetes
Cancer	Other

### Pleas list any medications (prescription and over the counter) that you are currently taking:

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### Family History

Do you have a family history of hearing loss? Y / N

### Noise Exposure

Have you been exposed to loud levels of noise in the workplace? Y / N Hearing protection worn? Y / N

Do you have any recreational hobbies that involve loud equipment or noise? Y / N

Hearing protection worn? Y / N

### Amplification

Do you wear amplification? Y / N Right Ear or Left Ear Dispenser: \_\_\_\_\_

How old are your present aids? \_\_\_\_\_ How do you hear with your hearing aid(s)? \_\_\_\_\_

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In which circumstances do you continue to have difficulty hearing with your aid(s)? \_\_\_\_\_

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