Valley Vision Associates

Leo Oltman, H.I.S.

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

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

High blood pressure
Stroke
Cancer
Heart disease
Diabetes
Other

Please 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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