**Hearing Questionnaire**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: ­­­\_\_\_\_\_\_\_\_\_\_\_\_ Patient # \_\_\_\_\_\_\_\_\_\_

Office Use

Primary Care Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referring Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our practice? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have difficulty hearing? Yes No

Is the loss gradual or sudden? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is one ear poorer than the other? Yes No

Which ear is poorer? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you hear noises in your ears like ringing or buzzing? Yes No

Do you hear it in one or both ears? \_\_\_\_\_\_\_\_\_\_\_\_

Do you experience dizziness? Yes No

Has this been evaluated or treated? Yes No

Are you **or** have you been around loud noise consistently? Yes No

Do or did you wear hearing protection? Yes No

Do you have a history of ear infections? Yes No

Do you have a history of ear surgery? Yes No

What type of surgery? When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear hearing aids? Yes No

Do you have a history of head injury? Yes No

Do you have any family history of hearing loss? Yes No

Which members? ­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list your current or prior medical conditions:

Please list any hospitalizations or surgeries: