

ADULT HISTORY

Date: _____

Name: _____ Age: _____ Occupation: _____

What concerns you the most?

___Hearing Loss ___Dizziness ___Ear Noises ___Other_____

1. If you think you have a hearing problem, please answer the following, if not, go to # 2.

A. Do you have a problem in the following situations? (Please check)

___Listening to another person at a distance of six feet

___In groups and noisy places

___At work

___At home

___In social / recreational situations

___Using the telephone ___Left Ear ___Right Ear ___Both

B. From which ear do you hear better? ___Left Ear ___Right Ear ___Both

C. What do you think caused your hearing loss? _____

D. Did your hearing loss come on: ___Suddenly ___Gradually

E. When did you first notice a hearing loss? _____

F. Has it gotten worse over time? ___Yes ___No

G. Does it fluctuate from time to time? ___Yes ___No

H. Does anyone in your family have a hearing problem? ___Yes ___No

Who? _____

2. Have you ever had ear surgery? ___Yes ___No

3. Do you presently have tubes in your ears? ___Yes ___No

4. Do you take any medicines regularly? ___Yes ___No

5. Are you bothered by noises in your ears or head? ___Yes ___No

If "yes": ___Right Ear ___Left Ear ___Both Ears

6. Are you ever dizzy? ___Yes ___No

If "yes", Describe: _____

7. Have you been exposed to loud noises for a long time? ___Yes ___No

If "yes" how long? _____

8. Have you ever used a hearing aid in the past? ___Yes ___No

9. If you are using a hearing aid, please answer the following, if you are not go on to # 10.

A. Which ear is aided? ___Left ___Right ___Both

B. How long have you used an aid? _____

C. How long have you had your present aid? _____

D. Are you satisfied with the aid? ___Yes ___No

10. What do you want to learn from your visit today? _____
