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| **Patient Name: DOB:** | | | | |
| **Questions** | **Yes** | **No** | **Sometimes** |  |
| Do you think you may have hearing loss? |  |  |  | R /L/Both |
| Does your family complain about your hearing? |  |  |  |  |
| Do you have trouble hearing on the phone? |  |  |  | R/L/Both |
| Which ear do you use for the phone? |  |  |  | R/L/Both |
| Do people complain that the TV is too loud? |  |  |  |  |
| Do you have to strain to hear some conversations? |  |  |  |  |
| Do many people seem to mumble or not speak clearly? |  |  |  |  |
| Do you have trouble hearing in noisy background? |  |  |  |  |
| Do you misunderstand what others are saying and respond inappropriately? |  |  |  |  |
| Do you have trouble hearing the speech of woman and children? |  |  |  |  |
| Do people get annoyed because you sometimes misunderstand what they say? |  |  |  |  |
| Do you have ringing (tinnitus) in you ears? |  |  |  | R/L/Both |
| Do you have family history of hearing loss? |  |  |  | R/L/Both |
| Do you have a history of ear infections or other diseases of the ear? |  |  |  | R/L/Both |
| Have you had any head or ear injuries? |  |  |  | R/L/Both |
| Do you have sinus or allergy problems? |  |  |  |  |
| Do your ear canals itch? |  |  |  | R/L/Both |
| Do you wear hearing aids? |  |  |  | R/L/Both |
| Do you have any problems with your hearing aids? |  |  |  | R/L/Both |
| What hearing aid problems do you have? | Explain: | | | |
| Do you want information on hearing aids if our testing determines that you are a hearing aid candidate? |  |  | Explain: | |
| Do you have noisy Hobbies? | Explain: | | | |
| Do you work in a noisy environment? | Explain: | | | |
| Do you wear hearing protection? |  |  |  | R/L/Both |
| Anything else you want us to know? | Explain: | | | |