WEST COAST HEARING CLINIC
You should HEAR what you're missing!

Adult History Questionnaire

Name _____ Date _____

Person Completing Form _____

Primary Care Physician _____

Referring Physician _____

Have we seen you at this office before? ☐ Yes ☐ No

Describe problem or reason for this evaluation _____

Do you feel you have a hearing loss? ☐ Yes ☐ No ☐ Unknown

If ***YES***, please answer the questions below:

When did you first notice a hearing problem? _____

_____

Has the onset and progression of your hearing loss been ☐ Sudden ☐ Gradual

Severity of loss? _____

_____

Do you hear better in one ear than the other? ☐ Yes ☐ No

*If **YES**, in which ear do you hear better* ☐ Right ☐ Left

Does your hearing seem to fluctuate? ☐ Yes ☐ No

Do you experience fullness in your ears? ☐ Yes ☐ No

Can hear but have problems understanding? ☐ Yes ☐ No

Do you have hearing difficulty with: (Check all that apply)

☐ One-on-one conversations ☐ Small group conversations ☐ Concerts or plays ☐ Women's voices
☐ Large group conversations ☐ TV volume ☐ Children's voices ☐ Group of people with multiple talkers
☐ Movies ☐ Telephone conversations ☐ Presence of background noise ☐ Other _____

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Do you experience tinnitus (ringing or buzzing) in your ears or other head noises? ☐ Yes ☐ No

*If **YES**, please answer the questions below:*

In which ear(s) do you experience tinnitus ☐ Right ☐ Left ☐ Both

How long have you experienced tinnitus? _____

Is it high or low pitched? _____

Is it single noise or multiple sounds? _____

Is it a pulsation or rhythmic quality present? _____

Is it constant or intermittent? _____

If intermittent, how often and how long does it last? _____

Do you notice tinnitus in quiet situations? ☐ Yes ☐ No

Do you notice tinnitus in noisy situations? ☐ Yes ☐ No

Have you experienced dizziness within the last six months? ☐ Yes ☐ No

*If **YES**, please answer and circle the question below:*

Do you experience? ☐ Balance difficulty ☐ Lightheadedness ☐ Spinning sensation ☐ Other _____

Have you had any significant noise exposure either work or hobby related? ☐ Yes ☐ No

*If **YES**, please answer the questions below:*

Number of years exposed to noise _____

Job title/description _____

Employer at the time of noise exposure _____

Currently employed _____

Not currently employed _____

Date of retirement or termination of employment _____

Recreational activity or hobby of significant noise exposure _____

Hearing protection devices utilized? ☐ Yes ☐ No

How often hearing protection used? _____

Have you had any ear infections or drainage? ☐ Yes ☐ No

*If **YES**, please answer the question below:*

Please indicate, as a ☐ Child ☐ Adult ☐ Both

Last infection date? _____

History of medical conditions related to your hearing

Check all that apply

☐ Ear pain ☐ Perforation of the eardrum ☐ Soreness in the canal

☐ Laceration of the ear ☐ PE tubes ☐ Trauma to the ear

Ear surgeries? (Please list) _____

History of medical conditions

Check all that apply

☐ Acoustical trauma ☐ Cholesterol ☐ High blood pressure ☐ Allergies

☐ Diabetes mellitus ☐ Severe blow to the head ☐ Arthritis ☐ Disease accompanied by high fever

☐ Sinus problems ☐ Blurred vision ☐ Headaches ☐ Stroke

☐ Cancer ☐ Heart/cardiac problems

Tobacco use

Have you ever used tobacco products? ☐ Yes ☐ No

Do you currently use tobacco products? ☐ Yes ☐ No

Do you have any family members that had hearing loss before age fifty? ☐ Yes ☐ No

*If **YES**, please answer the question below:*

Relationship: _____

When was the last time you had your hearing tested? _____

Have you ever worn or tried hearing instruments? ☐ Yes ☐ No

*If **YES**, please answer the questions below:*

How long ago? _____