Kos/Danchak
AUDIOLOGY & HEARING AIDS

HEARING HEALTH HISTORY

Do you have a history of the following? Check all that apply:

☐ Ear Infections/Ear Surgery — Details: _____
☐ Noise Exposure — Type: _____
☐ Family History of Hearing Loss — Who: _____
☐ Family History of Tinnitus — Who: _____
☐ Family History of Sound Tolerance Issues — Who: _____

Do you experience dizziness? ☐ Yes ☐ No
Constant: _____ Episodic: _____ How frequent? _____
Dizziness triggers: _____
Does anything provide relief: _____
Associated changes in hearing or ringing/pressure in the ears: _____

Do you have ringing/noises in your ears (tinnitus)? ☐ Yes ☐ No Describe: _____
Constant: _____ Episodic: _____ When were you first aware of it: _____
Does anything seem to make your tinnitus change? _____
Have you seen other specialists about your tinnitus? ☐ Yes ☐ No
How many? _____ What were you told? _____
What tests were done, when and findings? _____

Are you extra sensitive to external sounds? ☐ Yes ☐ No
When did it start? _____ List the uncomfortable sound: _____
Treatments you have tried: _____
Have you seen other specialists about your sound sensitivity? ☐ Yes ☐ No
How many? _____ What were you told? _____

Do you suspect that you have a hearing loss? ☐ Right ☐ Left ☐ Both Poorer ear: _____
Cause: _____ Duration: _____
Does your hearing seem to fluctuate? ☐ Yes ☐ No Describe: _____
Has your hearing ever been tested? ☐ Yes ☐ No Findings: _____

Did/do you wear hearing aids? ☐ Yes ☐ No
Which ear? ☐ Right ☐ Left ☐ Both Brand & Model: _____
How long have you worn aids? _____ What styles have you worn? _____
When/where did you purchase them? _____ Hours/Day use: _____

Any problems with your aids?
Please list the top three listening situations where you would like to hear better:
1. 2. 3.

Place an "x" along the line indicating how much your hearing difficulties affect you:
No effect ◄——————————————————————► Affects communication daily
Place an "x" along the line indicating how motivated you are to get hearing help:
Not motivated at all ◄——————————————————————► Very motivated

How do you feel about your hearing loss (embarrassed, frustrated, etc.)? _____

Please list your most important considerations regarding hearing devices in rank order from one to four.
(1 being the most important, 4 being the least important.) Please use each number only once.
_____ Size and the ability of others not to see the hearing devices
_____ Improved ability to hear and understand speech
_____ Improved ability to hear and understand speech in noisy situations
_____ Cost of the hearing devices

Patient's Signature: _____ Date: _____

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