

NAME _____

DATE OF BIRTH _____

BACKGROUND INFORMATION

1. Have you ever had your hearing tested before? _____ When? _____
Recommendations: _____
2. Do you have one better ear? Right _____ Left _____
3. Was your hearing loss gradual or sudden? _____
4. Do you have noises or ringing in your ears? Yes _____ No _____
5. Are you bothered by sudden, loud sounds? Yes _____ No _____
6. Do any other members of your family have hearing problems? Yes _____ No _____
7. Have you had recent earaches? _____ Ear infections? _____ Ear discharge? _____
Surgery? _____
When: _____
Treatment: _____
Physician: _____
8. Do you or have you ever worked in a noisy place? _____
9. Do you have noisy hobbies: hunting, shooting, target practice, auto racing, carpentry, etc.?

10. Family physician: _____