ADULT HISTORY QUESTIONNAIRE

PATIENT NAME:_____ DATE:_____

What concern brought you here? (Please indicate below)

Hearing Loss_____ Balance Trouble_____ Ear/Head Noises_____ Other:_____

How were you referred to this Office?_____

If you have hearing difficulty, please check all of the following that apply:

_____Trouble hearing when in groups or noisy places

_____Trouble hearing over the telephone

Which ear do you use on the telephone?_____

_____Trouble hearing at work? In what situations?_____

_____Trouble hearing a person talking from a distance of more than 6 feet

Which ear hears better_____

How/When did you first notice your hearing loss?_____

Did your hearing loss come on suddenly_____or gradually_____

Have you ever had ear surgery?_____ If yes, please describe:_____

_____

Do you ever hear a humming or buzzing sound in your head or ear(s)?_____

If yes, please mark the following:

a. How often do you hear it? Constantly_____Comes and Goes_____At Night_____
b. Where do you hear it? Right ear_____ Left ear_____ Both ears_____ In head_____
c. What does it sound like?_____
d. When did you first become aware of it?_____
e. Can you associate it with an event or a change in medication?_____
   If yes, please describe:_____

Do any blood relatives have any hearing trouble? Yes_____ No_____ Don't Know_____

a. Please describe who:_____
b. Please describe their hearing loss:_____

Have you been exposed to loud noise due to work, hobbies or military service?_____

If yes, please describe:_____

Do you have trouble with your balance?_____

a. If yes, please describe:_____
b. Does anyone in your family have this trouble?_____
c. Do you ever feel "woozy" or "off" after making a particular movement or being in a particular position?
   _____ Please describe:_____
d. Do you have trouble with your gait (walking)?_____ Does anyone in your family?_____

Do you (or a blood relative) have any:

1. Blurring of vision? You_____ Family Member _____
2. Wear Glasses? You_____ Family Member_____
3. Numb fingers or strange sensations in your limbs? You _____ Family Member _____
4. Sensation of numbness, tingling or heavy feeling on your face? You_____ Family Member_____
5. Diabetes? You_____ Family Member_____
6. Kidney Problems? You_____ Family Member_____
7. More than one color of the eyes? You_____ Family Member_____
8. Unusual/unique outer shape ear? You _____ Family Member_____
9. Unusual/unique skeletal (bone) features? You _____ Family Member_____
10. History of easily broken bones? You _____ Family Member_____
11. Heart trouble or heart disease? You_____ Family Member_____
12. Premature graying of the hair? You _____ Family Member _____
13. History of headaches? You_____ Family Member_____
14. History of sinus trouble confirmed by sinus x-rays? You_____ Family Member_____

Have you ever used a hearing aid in the past? _____

a. Which ear? Right_____ Left_____ Both_____
b. How long have you used hearing aids?_____
c. How long have you had your present hearing aids?_____
d. What do you like about your hearing aids?_____
   _____
e. What do you dislike about your hearing aids?_____
   _____

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

_____

_____

Do you use tobacco?_____