

HEARING HEALTH HISTORY

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

- Ear Infections/Ear Surgery
- Noise Exposure
- Family History of Hearing Loss
- Family History of Tinnitus
- Family History of Sound Tolerance Issues

Details: _____
 Type: _____
 Who: _____
 Who: _____
 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? _____

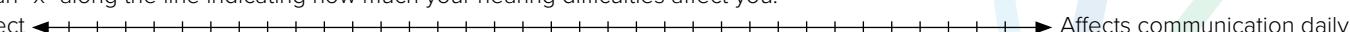
When/where did you purchase them? _____ Hours/Day use: _____

Any problems with your aids?

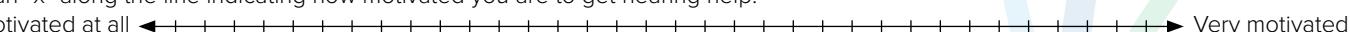
Please list the top three listening situations where you would like to hear better:

1. _____ 2. _____ 3. _____

Place an "x" along the line indicating how much your hearing difficulties affect you:

No effect 

Place an "x" along the line indicating how motivated you are to get hearing help:

Not motivated at all 

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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