Hearing Care Center

301-714-4390

Name _____ Occupation _____

Referred by _____ Date _____

Reason for referral _____

1. When did you first notice the problem? _____
2. Do you know the reason for this problem? _____
3. Has it become worse? If so, explain _____
4. Do you hear better in one ear? If so, explain _____
5. Any history of hearing loss in your family? If so, explain _____
6. Do you wear a hearing aid? Yes or No

   If yes, how long? _____

   Is it satisfactory? Please explain _____

7. Have you ever been exposed to loud noise, recently or in the past? Yes or No (please check (√) all that apply)

   □ Firearms □ Factory work □ Military equipment □ Power tools

   □ Music □ Farm equipment □ Explosions □ Heavy equipment

   □ Motorcycles/recreational vehicles □ other _____

8. Please check (√) if you have experienced any of the following:

   □ Excessive ear wax □ Ear drainage/bleeding □ Swimmer's Ear

   □ Ear pressure/fullness □ Popping sensation in the ear □ Ear pain

   □ Fluctuating hearing loss □ Fluid behind the eardrum □ Dizziness/Vertigo

   □ Sensitivity to loud noises

9. Please check (√) if you have been diagnosed with any of the following:

   □ Otosclerosis □ Cholesteatoma □ Sudden hearing loss

   □ Labyrinthitis □ Meniere's disease □ Barotrauma

   □ Permanent hearing loss □ Ossicular dislocation/fixation □ Acoustic neuroma

   □ Bell's palsy

10. Please list your current prescriptions, including vitamins, supplements, herbal remedies or over the counter:

	Medication	**Reason**
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

***If needed, please list additional medications on a separate piece of paper.**

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11. Have you ever used tobacco products of any kind? Yes or No

12. How many alcoholic drinks per week do you consume? _____

13. Please check (√) if you have experienced any of the following

□ Heart disease	□ Mumps	□ Kidney or renal problems
□ Stroke/TIA	□ Meningitis	□ Chronic sinus infections
□ Diabetes	□ Measles	□ Environmental allergies
□ High blood pressure	□ Scarlet fever	□ Cancer
□ Hypothyroidism	□ HIV/AIDS	□ Radiation/chemotherapy
□ Asthma	□ Tuberculosis	□ Long term IV antibiotics
□ Mental illness	□ Visual Problems	□ Head trauma
□ Depression or anxiety	□ Hepatitis A, B or C	□ Loss of consciousness
□ Migraines	□ Liver Problems	□ Exposure to chemicals/solvents

14. Please read through each listening situation and evaluate how well you hear. Also determine how important it is for you to hear in that situation.

	Hearing Quality					**Importance to you**		
	Poor				Good	Not	Somewhat	Very
Quiet (one on one conversation)	1	2	3	4	5	1	2	3
Television	1	2	3	4	5	1	2	3
Music	1	2	3	4	5	1	2	3
Leisure activities	1	2	3	4	5	1	2	3
Restaurants	1	2	3	4	5	1	2	3
Church	1	2	3	4	5	1	2	3
Meeting/groups	1	2	3	4	5	1	2	3
Work place	1	2	3	4	5	1	2	3
Telephone	1	2	3	4	5	1	2	3
Car	1	2	3	4	5	1	2	3
Male voice	1	2	3	4	5	1	2	3
Female voice	1	2	3	4	5	1	2	3
Child's voice	1	2	3	4	5	1	2	3

15. What do you hope to gain from this testing? _____