Ear, Nose, & Throat Associates
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Name: _____ Date: _____

What do your friends call you? _____ Spouse: _____
Male ___ Female ___ How many children do you have? _____ Grandchildren? _____
Date of Birth: _____
Address: _____
City: _____ State: _____ Zip: _____ Phone: _____
PrimaryPhysician: _____
Insurance Name: _____ Tel#: _____
Referred By: _____
Occupation: _____ If retired, what kind of work did you do? _____

Will this be your first hearing test? Yes_____ No_____
Have you been examined by a doctor in the past 6 months? Yes_____ No_____
Have you ever had ear surgery? Yes_____ No_____
Has the hearing in one ear rapidly decreased within the last 90 days? Yes_____ No_____
Have you experienced acute or recurring dizziness? Yes_____ No_____
In which ear is your hearing impaired? Left_____ Right_____ Same_____
When did you notice your hearing loss? _____Years
Did your hearing loss develop Suddenly_____ Gradually_____
Do you know the cause of your hearing loss? Yes_____ No_____
Cause _____
Are you experiencing ear pain? Yes_____ No_____
Have you noticed any change in your ability to remember? Yes_____ No_____
Do you have ringing of the ears? Yes_____ No_____
Do you sometimes hear conversation loud enough but cannot understand the words? Yes_____ No_____
Do you often ask others to repeat? Yes_____ No_____
Do your find it difficult to understand conversation in noise? Yes_____ No_____
Do you have trouble hearing on the telephone? Yes_____ No_____
Do you have difficulty hearing significant others? Yes_____ No_____
Do others mention you play the radio or TV too loudly? Yes_____ No_____
What comments have others made about your hearing? _____
In what situation do you have the most difficulty understanding?

I wear a hearing aid in my: _____Left ear _____Right ear _____Both ears,
But, still experience:
____ I have trouble understanding in group situations.
____Some sounds are too loud.
____Everything sounds tinny.
____The hearing aid whistles.
____I have trouble with background noise,
____My voice sounds hollow and unnatural.
____My ears feel plugged.
____Telephone use is difficult for me.
____I have trouble hearing the TV.

Signed: _____ Date: _____

04-2012