DeFatta
ENT & ALLERGY

Name: _____

DOB:_____

Adult Hearing Health History

Do you feel like you have a hearing loss? ☐ **Right** ☐ **Left** ☐ **Both** ☐ **No**

Is there a family history of hearing loss? ☐ **Yes** ☐ **No**

If yes, who?

_____

Have you recently had any ear pain? ☐ **Yes** ☐ **No**

Have you recently had any ear drainage? ☐ **Yes** ☐ **No**

Have you recently had any pressure in your ears? ☐ **Yes** ☐ **No**

Have you had ringing/buzzing in your ears? ☐ **Right** ☐ **Left** ☐ **Both** ☐ **No**

Have you had any dizziness? ☐ **Yes** ☐ **No**

Explain:

_____

Do you have a history of ear infections/ear surgery? ☐ **Yes** ☐ **No**

Do you have a history of noise exposure? ☐ **Yes** ☐ **No**

Use of firearms? ☐ **Yes** ☐ **No** **Routine hearing test at work?** ☐ **Yes** ☐ **No**

Did you serve in The armed forces? ☐ **Yes** ☐ **No** **Have you ever operated heavy equipment?** ☐ **Yes** ☐ **No**

Did work require hearing protection? ☐ **Yes** ☐ **No** **History of factory work?** ☐ **Yes** ☐ **No**

History of loud music? ☐ **Yes** ☐ **No** **Did you grow up on farm?** ☐ **Yes** ☐ **No**

Have you had a hearing test done recently? ☐ **Yes** **When:**_____ ☐ **No**

Where:_____

Amplification History

Do you wear or have you ever worn hearing aids? ☐ **Right** ☐ **Left** ☐ **Both** ☐ **No**

If not, will you wear a hearing aid if it can help you hear better? ☐ Yes ☐ No

If yes, and you could improve something about your current hearing aids, what would it be?

Explain:_____

_____