Mid-Valley ENT & Allergy
ENT Hearing & Balance Center

# HEARING QUESTIONNAIRE

Name: _____ DOB: _____ Today's Date: _____

1. What is your primary reason for coming in today? _____
2. Do you or do other people think you have a hearing problem? ☐ Yes ☐ No
3. Which ear? ☐ Left ☐ Right ☐ Both
4. How long have you been aware of hearing loss? _____
5. Have you worn a hearing aid before? ☐ Yes ☐ No How long? _____
6. If so, were the hearing aid(s) helpful or beneficial? ☐ Yes ☐ No ☐ Sometimes
7. Where did you obtain your current hearing aids? _____

**HISTORY OF NOISE EXPOSURE:**

8. Have you ever worked in noise or been exposed to noise recreationally? ☐ Yes ☐ No
   How long? _____ Explain: _____

**MEDICAL:**

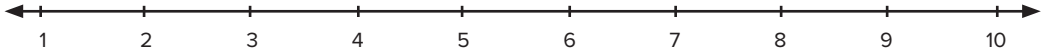
9. History of head injury? ☐ Yes ☐ No If yes, explain: _____
10. History of ear infections or ear surgeries? ☐ Yes ☐ No If yes, explain: _____

**HEARING HISTORY:**

11. Is there a history of hearing loss in your family? ☐ Yes ☐ No
12. **Do you have difficulty with any of the following? Please check.**
    - ☐ Asking people to repeat themselves or saying "what" a lot
    - ☐ Watching TV
    - ☐ Hearing on the phone? ☐ Left ear ☐ Right ear ☐ Both
    - ☐ Hearing in meetings?
    - ☐ Conversation in noisy restaurants?
    - ☐ Hearing at church?
    - ☐ Hearing in a group?

In what situation(s) are you most concerned or frustrated with your hearing? Explain: _____

11. On a scale of one 1 to 10, with 1 being the worst and 10 being the best, how would you rate your overall hearing ability?




*Worst (can't hear)* *Best (no problems)*

12. What is your general lifestyle? ☐ Quiet at home ☐ Busy and active ☐ Working ☐ Retired ☐ Explain: _____
13. Do you have ringing or noises in your ears? ☐ Yes ☐ No ☐ Occasional ☐ Constant
14. Ringing in which ear? ☐ Left ☐ Right ☐ Both Does it keep you awake? ☐ Yes ☐ No
15. Describe the sound: ☐ Ringing ☐ Buzzing ☐ High pitch ☐ Other
16. How long have you had the ringing? _____
17. Do you have dizziness, vertigo or balance problems? ☐ Yes ☐ No How long? _____ Explain: _____

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