



HEARING QUESTIONNAIRE

1. Do you suspect a hearing loss? Yes No
2. Have you ever worn a hearing aid? Yes No
3. Which situations cause the greatest difficulty in hearing?
 TV Telephone Home Work
 Soft Voices Parties Large Groups Lectures
 Other: _____
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4. Which ear do you customarily use on the telephone? Left Right
5. Have you been exposed to loud noises at work? Yes No
6. Have you been exposed to loud noises during recreation? Yes No
7. Do you have any family members with hearing problems? Yes No
8. Do you have any family members with hearing aids? Yes No
9. Do you ever experience dizziness? Yes No
10. Do you ever experience tinnitus or experience ringing or hear other noises in your ears? Yes No
11. Have you ever been treated for heart disease? Yes No
12. Have you ever been treated for cancer? Yes No
13. Have you ever been treated for diabetes? Yes No
14. Have you ever suffered a head injury? Yes No
15. Are you currently on medications? Yes No
If yes, please list: _____

16. Do you have any allergies? Yes No
If yes, please list: _____
