Superior Audiology
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Adult Hearing Health Questionnaire

Patient Name: _____ Date of Birth_____ Today's date: _____

Referring Physician: _____

Reason for today's appointment: _____

Date/Location of previous hearing evaluation: _____

List of current medications (or provide front office with list to copy):

_____

Do you smoke? YES NO

Ear Health History

Do you feel like you have hearing loss? YES NO

If Yes, is hearing loss worse RIGHT EAR LEFT EAR BOTH

If Yes, how long have you experienced hearing loss? _____

Have you worn hearing aids in the past? YES NO

Do you hear any noises such as ringing in your ears? YES NO

If Yes, is noise worse loss worse RIGHT EAR LEFT EAR BOTH

Do you suffer from acute or chronic dizziness? YES NO

Do you experience any ear pain or discomfort? YES NO

Have you ever had any ear surgeries? YES NO

Have you ever been exposed to loud sound/noise? YES NO

Have you ever received chemotherapy? YES NO

How is your general health? _____

Other concerns regarding ear health you would like to discuss with the doctor today:

_____

_____