

Ear History:

Have you ever seen an ear doctor? Name: _____ Date: _____

Have you ever had ear surgery? Type: _____ Where/When: _____

Have you ever had your hearing tested? Yes No Date of Test: _____

Tested by: _____ Results of test: _____

Do you have ringing in your ears? Yes / No If yes please describe the sound _____

Have you been exposed to excessive noise? Yes / No What? _____

Do you now or have you ever worn a hearing instrument? Yes No Date Fit: _____

What brand/type? _____ Results? _____

Diseases of the ear: *Have you ever been diagnosed with the following conditions?*

Meniere's	___Yes	___No	___Not Sure
Cholesteatoma	___Yes	___No	___Not Sure
Mastoiditis	___Yes	___No	___Not Sure
Labyrinthitis	___Yes	___No	___Not Sure
Otitis Media/Chronic ear infections	___Yes	___No	___Not Sure

About Your Hearing:

Do your friends and/or family complain that you do not hear well? Yes / No

If yes, what do they notice about your hearing or how would they describe your hearing problems:

How long have you had a hearing problem? _____

Perception of Hearing Questionnaire:

Listed below are several statements that describe hearing difficulties you may encounter. Please indicate how often you think each situation is true.

	Seldom					Always
Understanding all the words in a conversation clearly	1	2	3	4	5	5
Problems hearing over the phone	1	2	3	4	5	5
Trouble following conversation in a small group of people	1	2	3	4	5	5
Trouble understanding TV	1	2	3	4	5	5
Trouble understanding in large rooms like lecture halls	1	2	3	4	5	5
Trouble understanding in restaurants and parties	1	2	3	4	5	5
Confusion about where sounds are coming from	1	2	3	4	5	5
Often have to ask people to repeat themselves	1	2	3	4	5	5
Misunderstanding instructions given by doctors and pharmacists	1	2	3	4	5	5
Find that people sound like they are mumbling or not speaking clearly	1	2	3	4	5	5
Trouble conversing in the car	1	2	3	4	5	5