

HISTORY OF HEARING LOSS

NAME: _____

DATE: _____

Type of hearing loss (check all that apply): ☐ Sensorineural ☐ Conductive ☐ Mixed ☐ Unknown
☐ Sudden ☐ Congenital ☐ Progressive ☐ Fluctuating

First year hearing loss noticed: _____

Cause of hearing loss: _____

Family History of hearing loss: ☐ Yes ☐ No

If Yes, who: _____

History of loud noise exposure: ☐ Yes ☐ No If Yes, what: _____Better hearing ear: ☐ Right ☐ Left ☐ Neither

History of Tinnitus: _____

History of ear infections/pain/ ear surgery: _____

History of Dizziness: _____

Significant Medical History (e.g. diabetes, pace maker, Meniere's etc.): _____

History of hearing aid use: _____

Ever worn hearing aids: ☐ Yes ☐ No

Year first hearing aids fit: _____

How many sets of hearing aids have been used: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5+Have you worn hearing aids consistently: ☐ Yes ☐ No

Can you understand speech in the following situations:

Quiet environments: ☐ Yes ☐ No ☐ SometimesSmall groups (3-5 people): ☐ Yes ☐ No ☐ SometimesLarge groups (5+ people): ☐ Yes ☐ No ☐ SometimesTV without captions: ☐ Yes ☐ No ☐ SometimesOver the phone: ☐ Yes ☐ No ☐ Sometimes; Do you have a Cap Tell Phone? _____