OKLAHOMA HEARING CENTER
ADULT HEARING QUESTIONNAIRE

DATE: _____ NAME: _____ ACCT: _____
DATE OF BIRTH: _____ SSN: _____
ARE YOU CURRENTLY RECEIVING HOME HEALTH CARE; YES _____ NO _____
REFERRING DOCTOR: _____
PRIMARY CARE PHYSICIAN: _____
ENT (EAR, NOSE, THROAT) PHYSICIAN: _____
DATE LAST SEEN BY ENT: _____

CURRENT MEDICATIONS: _____
_____
_____

HEARING HISTORY
DO YOU HAVE DIFFICULTY HEARING: _____
ONE EAR OR BOTH EARS? WHICH ONE? _____
FOR HOW LONG? _____

DO YOU HAVE A HISTORY OF EXPOSURE TO LOUD SOUNDS? (MILITARY, CONSTRUCTION, MOTORSPORTS, HUNTING, ETC.) IF SO, PLEASE EXPLAIN: _____
_____

WHAT SITUATIONS DO YOU NOTICE DIFFICULTY HEARING? _____

ARE CERTAIN SOUNDS PAINFULLY LOUD TO YOU? _____ YES _____NO
PLEASE EXPLAIN: _____

WHEN WAS YOUR LAST HEARING TEST? _____

PLEASE CHECK ALL ITEMS THAT APPLY:

____FULLNESS/ STUFFINESS IN EARS
____DIZZINESS/VERTIGO
____IMBALANCE
____MEASLES
____MUMPS
____RUBELLA
____DISCHARGE FROM EARS
____HEADACHES/MIGRAINES
____ALLERGIES
____CURRENT OR PREVIOUS HISTORY OF SMOKING
____FAMILY/FRIENDS COMPLAIN ABOUT YOUR HEARING
____FAMILY MEMBER WITH HEARING LOSS
____NUMBNESS/TINGLING IN FACE
____TV TURNED UP LOUDER THAN OTHERS
____EAR SURGERY
____DIABETES
____EAR PAIN
____FLUCTUATING HEARING
____TMJ PROBLEMS
____HIGH/LOW BLOOD PRESSURE
____RINGING OR SOUNDS IN EARS
____PACEMAKER OR IMPLANTABLE DEVICE(S)

HAVE YOU WORN HEARING AIDS BEFORE? IF SO, WHAT STYLE? HOW LONG?
_____

ARE YOU HAVING DIFFICULTY WITH YOUR CURRENT HEARING AIDS? _____ YES _____NO
WOULD YOU LIKE TO RECEIVE INFORMATION ABOUT HEARING DEVICES? _____ YES ____NO