ADVANCED Hearing Centers™ *Advanced Hearing Center*

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AUDIOLOGY HISTORY

Date:

What difficulties are you having with your ears and/or hearing?

☐ Pain Fullness/Pressure ☐ Dizziness ☐ Gradual Hearing Loss
☐ Ear Infections ☐ Sudden Hearing Loss ☐ Ringing In The Ears

Please explain all checked: _____

_____

_____

○ Yes ○ No Do You Have Any Relatives With Hearing Loss?

○ Yes ○ No Have You Been Exposed To High Levels Of Noise?

If yes, please describe: _____

○ Yes ○ No Have You Had Surgery In One Or Both Ears?

If yes, please describe: _____

○ Yes ○ No Have You Been Treated With Chemotherapy?

○ Yes ○ No Have You Seen A Physician About Your Ears In The Past 6 Months?

○ Yes ○ No Is This Your First Hearing Evaluation?

If You Had A Hearing Evaluation, When Was It And What Were The Results?

_____

If You Are Having Hearing Difficulties, Please Check All That Apply.

☐ Noisy Situations ☐ Quiet Situations ☐ Groups ☐ Car ☐ Phone ☐ Music ☐ Large Rooms

○ Yes ○ No Do You Currently Wear Hearing Aids?

If You Do, What Brand And Model? _____

If You Could Improve Your Current Hearing Aid Perfomance, What Would You Change?

_____

_____