

NAME _____ DATE _____

PLEASE CIRCLE OR CHECK APPROPRIATE ANSWERS

Do you notice hearing difficulty? *No Yes: Right Left Both*

Do you have tinnitus (ringing or buzzing in ears/head)? *No Yes: Right Left Both*

Do you have feelings of pressure or fullness in the ear(s)? *No Yes Right Left Both*

Do you have any dizziness or balance problems? *No Yes Both*

Do you notice increased difficulty hearing in noisy places? *No Yes*

Do you have difficulty hearing on the telephone? *No Yes*

Which ear do you prefer to use while speaking on the phone? *Right Left*

Do you like TV or music louder than others? *No Yes*

Do family or friends comment that you aren't hearing well, or do they need to repeat things for you? *No Yes*

Are very loud sounds uncomfortable for you? *No Yes*

Is there any family history of hearing loss? *No Yes Unsure*

Have you ever had medical ear problems: infections, drainage, pain, perforations of the eardrum, or ear surgeries? *No Yes*

Have you been exposed to very loud noise (guns, equipment, explosions, music)?
No Yes

Have you ever worn hearing aid(s)? *No Yes: Right Left Both*

Do you presently use it (them)? *No Yes Not applicable (N/A)*

Rate your satisfaction with your hearing aid(s): *Good Fair Poor N/A*

Are you considering (check one): *First-time trial with hearing aid(s)*

 Replacing present hearing aid(s) *Uncertain* *N/A*