# Hearing Health Questionnaire

Patient Name: _____ Date: _____

## HEARING HEALTH HISTORY

Do you have any history of or active drainage from either ear within the past 90 days? ☐ Yes ☐ No
Have you noticed any sudden or rapidly-progressing hearing loss in the past 90 days? ☐ Yes ☐ No
Do you believe you have a better-hearing ear? ☐ Yes ☐ No If yes, which ear is better? ☐ Right ☐ Left
If yes, how would you describe this difference between ears? ☐ Longstanding ☐ Recent (within past year)
Are you a diabetic? ☐ Yes ☐ No
Do you have any heart issues? ☐ Yes ☐ No
Do you have any ringing in your ears? ☐ Yes ☐ No
Have you previously had a hearing test? ☐ Yes ☐ No If yes, by whom? _____
Date of test: _____
Have you received any medical or surgical treatment for your ear(s) and/or a hearing loss? ☐ Yes ☐ No
If yes, when? _____ Physician/ENT: _____
Type of procedure: _____
Have you experienced any pain, pressure, or fullness in either ear over the past 90 days? ☐ Yes ☐ No
Have you experienced any acute or chronic dizziness? ☐ Yes ☐ No
If yes, have you discussed this with your physician? ☐ Yes ☐ No

## AMPLIFICATION HISTORY

Do you currently use hearing aids? ☐ Yes ☐ No Type: _____ Ear(s) Fitted: ☐ Both ☐ Right ☐ Left
Do you know anyone who wears hearing aids? ☐ Yes ☐ No
Is there anything you would choose to improve about your current hearing instruments? _____
_____
_____
_____
Hearing Care Professional: _____ ☐ Audiologist or ☐ Hearing Instrument Specialist

## COMMUNICATION NEEDS ASSESSMENT

Who encouraged you to come in today to see an audiologist? _____
How long have you noticed any difficulty hearing? _____
What concerns you most about your hearing/understanding and communication difficulties? _____
_____
What is it that made you decide to come here *today*? _____
_____
Do you have problems with dexterity? ☐ Yes ☐ No
Do you own a smartphone? ☐ Yes ☐ No Brand/model of smartphone (if known): _____

PEDIATRIC HEARING HISTORY

**MEDICAL HISTORY:** (*Please check all that apply.)*

☐ Jaundice ☐ Measles ☐ Mumps ☐ CMV ☐ Head Trauma ☐ IV Antibiotics ☐ Meningitis
☐ Ear Pain ☐ Ear Drainage ☐ Hole in the Eardrum(s) ☐ Middle Ear Fluid ☐ Patched Eardrum Hole
☐ Pressure (Ear) Tubes ☐ Chronic Ear Infections. If yes, total number: _____ and most recent episode: _____
☐ Allergies ☐ Dizziness ☐ Sinus or Upper Respiratory Infections ☐ Autism Spectrum Disorder
☐ Hearing Loss ☐ Ringing in Ears ☐ Attention Deficit / Hyperactivity Disorder (AD/HS)
☐ Other Medical Condition(s) _____

Is there a family history of hearing loss or hearing difficulties? ☐ Yes ☐ No
If yes, who has these problems? ☐ Mother ☐ Father ☐ Sibling ☐ Uncle ☐ Aunt ☐ Grandparent ☐ Cousin

**DEVELOPMENTAL HISTORY:**

Was a newborn hearing screening performed on your child? ☐ Yes ☐ No
Newborn hearing screening results: ☐ PASS *(circle one)*: Right / Left / Both ☐ FAIL/REFER: Right / Left / Both
Were there any pregnancy/birth complications? ☐ Yes ☐ No
If yes, these complications were…
☐ Before Birth. Please describe: _____
☐ During Birth. Please describe: _____
☐ Premature Birth. If so, how early? _____
☐ Low Birth Weight. If so, what was your child's weight? _____
☐ Low APGAR Score
☐ Meconium Poisoning
☐ Received (Mechanical) Oxygen

*(Please check all that apply.)*

☐ Speech or Language Delay ☐ Motor Developmental Delay
☐ Other Developmental Delay / Disorder _____
☐ Receives Therapy: ☐ Speech / Language ☐ Occupational ☐ Physical ☐ Other: _____

Are you concerned with your child's educational performance? ☐ Yes ☐ No

**HEARING & LISTENING**:

Does your child have any significant history of exposure to loud noise? ☐ Yes ☐ No
If yes, please describe: _____
*(Please check all that apply.)*
My child…
☐ Seems to hear but not understand ☐ Often asks "huh?" or "what?" ☐ Asks for speakers to repeat themselves
☐ Talks loudly ☐ Listens to TV / radio at high volume ☐ Sensitive to average or loud sounds
☐ Startles to loud sounds ☐ Has difficulty hearing in noise ☐ Has difficulty following multi-stage verbal directions
☐ Does opposite of what is asked of him/her ☐ Has difficulty remembering what is heard
☐ Has difficulty determining location of sounds ☐ Misunderstands rapid / softspoken / muffled speech
☐ Has difficulty discriminating speech sounds
Do you think your child has a problem with listening or understanding? ☐ Yes ☐ No
If yes, please describe: _____
Does your child's teacher or another professional involved with your child think your child has a problem with listening or understanding? ☐ Yes ☐ No
If yes, please describe: _____