PROFESSIONAL
HEARING AID CENTER

HEARING HISTORY

Today's Date: _____/_____/_____ Date of Birth: _____/_____/_____

First Name: _____ Last Name: _____

1. Have you ever worn a hearing aid? ☐ YES ☐ NO
   If yes, which ear(s): ☐ Left ☐ Right ☐ Both
   If yes, were you satisfied with your hearing aids? ☐ Yes ☐ No
   If no, why not? _____
2. Have you ever had surgery on your ears? ☐ YES ☐ NO
   If yes, which ear(s): ☐ Left ☐ Right ☐ Both
3. Do you have earaches, infections, or drainage? ☐ YES ☐ NO
   If yes, which ear(s): ☐ Left ☐ Right ☐ Both
4. Do you have difficulties with balance or dizziness? ☐ YES ☐ NO
5. Have you been exposed to loud noises? ☐ YES ☐ NO
6. Please rank the following questions from 1 to 5 with 1 being the least and 5 being the most:
   a) How important is it for you to hear better?
      Not very important ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very important
   b) How motivated are you to wear hearing aids?
      Not very motivated ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very motivated
   c) How well do you think hearing aids will improve your hearing?
      Not helpful at all ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 Very helpful
7. Please list the top three situations where you would most like to hear better.
   a) _____
   b) _____
   c) _____