The
HEARING &
BALANCE
Lab, PC

# Patient History Questionnaire

**Patient Name: ___________________________ Date: _____________________**

1. Do you feel you have a hearing loss? ..........................................................YES NO
   If YES, please answer the questions below:
   a) How long have you had the problem? _______
   b) Severity of loss _______________________________________________
   c) Do you hear better in one ear than the other? Please circle: RIGHT or LEFT

2. Do you hear ringing or buzzing in your ears or other head noises?...............YES NO
   If YES, please answer the questions below:
   Please circle which ear(s): Right Left Both
   How long has the noise been present? __________________
   High or low pitched? ______________________________
   Single noise or multiple sounds? ______________________
   Pulsation or Rhythmic quality present? _________________
   Constant or Intermittent? _____________________________
   If intermittent, how often and how long does it last? ____________________

3. Have you had any ear infections, drainage or ear surgeries?...........................YES NO
   If YES, please answer the questions below:
   Please indicate as a: Child Adult Both
   Last infection date: ___________________

4. Have you had any significant noise exposure either work or hobby related?...YES NO
   If YES, please answer the question below:
   Describe how long and what types: _________________________________________
   ___________________________________________________________________

5. Do you have any family members that had hearing loss before age fifty? YES NO
   If YES, please answer the question below:
   Relationship: ___________________________________________________

6. Have you experienced dizziness within the last six months?..........................YES NO
   If YES, please answer the question below:
   Circle if you experience: Lightheadedness Spinning Sensation

7. Have you ever worn or tried hearing instruments? ......................................YES NO
   If YES, please answer the questions below:
   How long ago? _____ Where did you purchase them?___________________

8. When was the last time you had your hearing tested and where?
   ___________________________________________________________________

9. Check all that apply to your hearing difficulties:
   - □ Difficulty hearing some people’s voices on the telephone
   - □ One-to-one conversations
   - □ In the presence of background noise
   - □ Groups of people or multiple talkers
   - □ Women and children voices
   - □ TV volume is loud to others

10. List medications that you are taking and **<u>for what reason</u>**?