Mid-Valley Hearing Center
Adult Audiological History

Name:_____
Date:_____

Reason for Visit:_____

1. Do you have or have you had any of the following (please check)

☐ Hearing problems ☐ Ear deformity or injury ☐ Head injury ☐ Stroke

☐ Ear noises/tinnitus ☐ Ear drainage ☐ Diabetes ☐ Sound Sensitivity

☐ Ear infections ☐ Ear pain ☐ Punctured eardrum ☐ Pacemaker

☐ Ear surgery ☐ Dizziness ☐ Sudden hearing loss ☐ Tobacco Use

☐ Pressure or fullness in ear ☐ Exposure to loud sounds

2. Do you have any relatives with hearing loss that started before age 70? ☐ Yes ☐ No

3. Have you had your hearing tested before? ☐ Yes ☐ No

If Yes, When? _____ Where? _____
If Yes, were you told you had a hearing problem? ☐ Yes ☐ No

4. Does anyone else feel you have a hearing problem? ☐ Yes ☐ No Who?_____

5. If you have a hearing loss, how long have you noticed it? _____

6. If you think you have a hearing loss, in what situations do you have difficulty?
   1. _____
   2. _____
   3. _____

7. Do you wear hearing aids or have you worn them in the past? ☐ Yes ☐ No
   If Yes, when and where did you get your hearing aids? _____
   If Yes, are you having any problems with your hearing aids? _____

8. Is there anything else you would like us to know about your hearing?
_____
_____

9. List any medical problems: _____
_____
_____

10. List any medications you are taking, excluding vitamins: _____
_____
_____