

**ADULT HEARING HEALTH PROFILE**

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

1. Do you have a hearing loss in one or both ears? Right Left Both Unsure  
If yes, how long have you noticed a hearing loss?  
 Recently (<90days)  Less than 1 year  1-5 years  Over 5 years
2. Do you have any noises/ringing in your ears? Yes/No
3. Do you have any pain or discomfort in your ears? Yes/No
4. Have you had any surgeries or medical problems with your ears? Yes/No
5. Is there a history of deafness or hearing loss in your family? Yes/No
6. Have you been or are you exposed to loud noise/music regularly (i.e. military, guns, concerts, occupational)? Yes/No
7. Are you a veteran, who qualifies for veteran's benefits? Yes No
8. In which of the following situations do you find difficulty hearing, if any?
 

<input type="checkbox"/> One-on-one conversations	<input type="checkbox"/> Restaurants/crowds/large groups
<input type="checkbox"/> T.V./Radio	<input type="checkbox"/> In the car
<input type="checkbox"/> Small groups	<input type="checkbox"/> Church/synagogue/movie theaters
<input type="checkbox"/> Business Meetings	<input type="checkbox"/> Understanding on the phone
<input type="checkbox"/> Hearing the doorbell/phone ring	<input type="checkbox"/> Golfing or other sports
<input type="checkbox"/> Hear some people, not others	<input type="checkbox"/> Other _____
9. Do others suggest that you have a hearing problem? Yes/No
10. Check any of the following medications you have taken:
  - Streptomycin
  - Tobramycin (Necin)
  - Gentamycin (Garamycin)
  - Kanamycin (Kantrey)
  - Ethacrinic Acid (Edecrin)
  - Furosemide (Lasix)
  - Anti-Cancer medication
  - Anti-Siezuers medications
  - Blood Pressure Pills
  - Birth Control Pills
  - Salicylates (aspirin)

\*\*\*\*\*Current Hearing Aid Users Only\*\*\*\*\*

What type of hearing aids are you using? \_\_\_\_\_

Describe your experience with your current hearing aids:

- Satisfied  Undecided  Dissatisfied  Not working