Newport Beach Hearing Aid Associates
Hearing Questionnaire

Patient Name: ________________________________ Today's Date: ________________

Date of Birth: _______________________ Age: _______________

Current Medications: (Please list over the counter & prescription medications)

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Allergic to Medications: Please list or mark none if no known medication allergies

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Reason for your visit today (circle one or both): Hearing Test Hearing Aid Evaluation

Do you or have you experienced any of the following (circle all that apply):

Hearing Loss Ear Pain Drainage Fullness Dizziness/Vertigo

Eardrum Perforation Ear Surgery Itchy Ears Exposure to Loud Noises

Family History of Hearing Loss Diabetes Stroke Scarlet Fever

Mumps Meningitis Cancer (specify type):____________________________

Is your hearing better in one ear? Yes No Which Ear? Left Right

Do you have tinnitus/ringing in the ears? Yes No Which Ear? Left Right

Is the tinnitus (circle one) Constant Intermittent/Occasional

Have you experienced sudden/rapid hearing loss within the past 90 days? Yes No

Do you have hearing aids? Yes No

Which ear? Left Right Both

Do you wear the hearing aids? Yes No If yes? How often: _________________

How old are the hearing aids? ______________________________

Are you happy with the benefits your current hearing aids provide? Yes No

If you could change/improve something about your hearing aids, what would you change?

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How were you referred to our office?

[ ] Physician (please provide name): ____
[ ] Friend/another patient
[ ] Insurance
[ ] Internet/website
[ ] Local advertising
[ ] Other: ____

Patient Signature: ____ Date: ___________

(Guardian signature for patients under 18 years old)