

The SPEECH AND HEARING CENTER

600 NORTH HOLTZCLAW AVENUE SUITE 200
CHATTANOOGA, TN 37404 TELEPHONE 423-622-6900

ADULT HEARING HISTORY-CONFIDENTIAL INFORMATION

Name: _____ Date of Birth _____

Who referred you to The Speech and Hearing Center? _____

Reason for Referral? _____

Name of Primary Care Physician: _____

Please answer the following questions about your hearing:

Do you have a hearing problem? -----

YES	NO
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What do you think caused your hearing problem? _____

How long have you had this difficulty? _____

Has it changed recently? -----

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Please explain: _____

Have you ever had ear surgery? -----

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Please explain: _____

Which ear is better? Please circle: Right Left Same

Do you have discomfort (pain or pressure) in your ears? -----

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Please explain: _____

Are you having any dizziness or balance problems? -----

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Please explain: _____

Do you have ringing in your ears or other head noises? -----

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Right **Left** **Constant** **Frequent** **Occasional**

Please rate the loudness of the noise or ringing: Mild _____ Moderate _____ Severe _____

Please describe the sound you hear in your head or ear: (ie. ringing, buzzing, frying, roaring, voices)

Have you been exposed to loud sounds? -----

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(examples: guns, saws, loud machines, loud music)

Please Describe: _____

Do any of your family members have a hearing problem? -----

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Please Answer Questions on the Front and Back of this Form

YES **NO**

If yes, please state relationship and explain: _____

Have you ever worn a hearing aid? -----
If so, how many years? _____

Are you wearing a hearing aid(s) now? -----
Right **Left**

Where do you have difficulty hearing? (ie. Restaurants, Church, Family gatherings, TV, Telephone)

Describe any additional physical or medical problems: _____

List any medications you are currently taking: _____

Are you interested in wearing hearing aids? _____

Signature of the person completing this form: _____

Date: _____

Relationship to patient: _____

Please Answer Questions on the Front and Back of this Form