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PATIENT QUESTIONNAIRE

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

General

Occupation \_\_\_\_\_

Does anyone in your family have a hearing problem? \_\_\_\_\_

When did you notice your hearing problem? \_\_\_\_\_

Have you had your hearing tested? \_\_\_\_\_ When? \_\_\_\_\_

What was the recommendation? \_\_\_\_\_

What caused your hearing loss? \_\_\_\_\_

Which is your better ear? Left \_\_\_\_\_ Right \_\_\_\_\_

Hearing-related History

Have you had ear surgery? Yes \_\_\_\_\_ No \_\_\_\_\_

Has your hearing changed in the past 90 days? Yes \_\_\_\_\_ No \_\_\_\_\_

Have you experienced or are you experiencing dizziness Yes \_\_\_\_\_ No \_\_\_\_\_

Did your hearing loss develop Suddenly \_\_\_\_\_ Gradually \_\_\_\_\_

Do you have ringing in the ear all the time? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have trouble hearing telephone conversations Yes \_\_\_\_\_ No \_\_\_\_\_

Do you keep your television loud? Yes \_\_\_\_\_ No \_\_\_\_\_

Can you hear the turn signals in the car? Yes \_\_\_\_\_ No \_\_\_\_\_

Ambulance sirens? Yes \_\_\_\_\_ No \_\_\_\_\_

Smoke alarms at home? Yes \_\_\_\_\_ No \_\_\_\_\_

Do you have a hearing aid? \_\_\_\_\_ Make and Model \_\_\_\_\_

Medical History

What medications are you taking? \_\_\_\_\_

Comments: \_\_\_\_\_

\_\_\_\_\_