PREMIER HEARING CENTER

www.premierhearing.com

PATIENT QUESTIONAIRE

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: _____

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