Scotch Institute of Hearing Health

A Division of Select Physicians Alliance, PL

Summergate Professional Center
27406 Cashford Circle
Wesley Chapel, FL 33544
Phone (813) 994-8900
Fax (855) 388-5350

Hearing Questionnaire

Patient Name: ______________________________ Date: ____________

1. Do you have difficulty hearing?
   a. Both ears? Y or N
   b. Right ear? Y or N
   c. Left ear? Y or N
2. Do you wear hearing aids?
   a. Right Hearing Aid? Y or N
   b. Left Hearing Aid? Y or N
3. When did you first notice your hearing loss? ______________________
4. Is your hearing getting worse? Y or N
5. Does your hearing fluctuate? Y or N
6. Do you hear any noise in your ears? Y or N
7. Do you have any ear pain? Y or N
8. Do you have any sensitivity to sound? Y or N
9. Do you have distortion of sound? Y or N
10. Do you have any fullness or stuffiness in your ears? Y or N
11. Do you have any ear drainage? Y or N
12. Have you had any ear surgery? Y or N
    a. If yes, what type?______________________________
    (Examples of common ear surgeries include ear tubes, Tympanoplasty, mastoidectomy, stapedectomy)
13. Have you ever worked in high noise level area? Y or N
14. Have you ever had any head or ear trauma? Y or N
    a. If yes, what type?______________________________
15. Have you been exposed to noise from weapon fire, blasts, or military occupational noise? Y or N
16. Do you have anyone in your family that is deaf or has severe hearing loss? Y or N
17. Circle any of the following medications you have taken:
    a. Streptomycin
    b. Tobramycin (Neecin)
    c. Gentamycin (Garamycin)
    d. Kanamycin (Kantrey)
    e. Ethacrinic Acid (Edecrin)
    f. Furosemide (Lasix)
    g. Salicylates (aspirin)
    h. Birth Control Pills
    i. Blood Pressure Pills
    j. Anti-Seizures medications
    k. Anti-Cancer medication

The above comprehensive history has been personally reviewed by the below listed doctors

Physician's Signature: ______________ Date: ____________________

Audiologist's Signature: ____________ Date: ____________________