

EAR, NOSE AND THROAT ASSOCIATES OF CHESTER COUNTY

HEARING QUESTIONNAIRE

Name: _____ DOB: _____

What is your reason for today's visit? _____

Have you had a hearing test previously? Yes No

If so, what were the results? _____

Do you have any tinnitus? (ringing, buzzing, hissing) Yes No

Which ear? Right Left Both

Since when? _____ Is it constant? Yes No

Have you ever worn a hearing aid? Yes No

Do you have difficulty hearing in any of the following situations (check all that apply):

____ Restaurants

____ Church or Other Place of Worship

____ Meetings/Groups

____ Telephone

____ Car

____ Television

____ Other: _____

Do you have problems hearing any certain voices?

Men

Women

Children

Have you stopped any activities because you had trouble hearing in that environment? Yes No If so, which? _____

Do you think you have a problem with your hearing? Yes No

Do any family members or friends think you have a problem with your hearing?

Yes No

Who sent you to our office?

Spouse

Self

Your children

Your grandchildren

Doctor

Friend

Other: _____