# *Augusta Hearing and Balance*

Adult Hearing History

NAME_____ DATE_____

Do you have hearing loss? YES NO

Which ear? RIGHT / LEFT / BOTH

Have you ever had your hearing tested? YES NO

If so, when? _____

Where? _____

Do you wear a hearing aid? YES NO

Are you happy with it? YES NO

Where and when was it purchased? _____

Do you have:

History of depression? YES NO

Dizziness or unexplained falls? YES NO

If yes, would you like to be referred for treatment? YES NO

Pain or discomfort in your ear? YES NO

Ear drainage? YES NO

Ringing or buzzing? YES NO

History of wax? YES NO

Do you use any tobacco products? YES NO

Do you have difficulty hearing/understanding in any of the following activities?

- ☐ Meetings
- ☐ One on one conversations
- ☐ Worship Service
- ☐ Restaurants
- ☐ Movies
- ☐ Watching TV
- ☐ Telephone

Please list current medications: _____

_____