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Adult Patient Questionnaire

Patient Name: _____ Date: _____

Date of Birth: _____ Report to MD: YES NO MD Name: _____

Have you had a hearing test? YES NO When? _____ Where? _____

What is the reason for your visit today? _____

Medical Info:

Diabetes Radiation (Head or Neck) Chemo Auto-Immune Tobacco Use

Ear Related Info:

Dizziness Trauma Noise Exposure Family History of HL

History of Surgery/Infection Tinnitus

Have you ever worn a Hearing Aid? YES NO Satisfied? _____

What would you like them to do better? _____

Why did you decide to have a test now? _____

explain test

Have you thought about a HA? _____

What is most important to you if you wear a HA? _____

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