Elizabeth Welch, Au.D.
Paige Lyon, Au.D.
Tylor Lyon, Au.D.

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 Hearing Loss

History of Surgery/Infection Tinnitus (Ringing in the Ears)

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? ____

Have you thought about a Hearing Aid? ____

What is most important to you if you wear a Hearing Aid? ____________________________

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