

Patient Hearing History Questionnaire

Patient Information

Company: _____

Birth Date: _____

SSN: _____

Language: _____

Name: _____

Sex: _____

AAO-HNS Medical Referral Criteria-1996:

Please circle your response.

Have you recently experienced pain in either ear?	Right	Left	Both	No
Have you recently experienced a draining ear?	Right	Left	Both	No
Have you recently experienced dizziness?			Yes	No
Have you recently experienced severe tinnitus (ringing)?	Right	Left	Both	No
Have you recently experienced sudden hearing loss?	Right	Left	Both	No
Have you recently experienced fluctuating hearing loss?	Right	Left	Both	No
Have you recently experienced ear fullness or discomfort?	Right	Left	Both	No
Have you recently had problems wearing hearing protection?			Yes	No

Medical History:

Have you ever served in the military?			Yes	No
Have you ever been to a doctor for an ear-related problem?	Right	Left	Both	No
Have you ever had a severe head injury?			Yes	No
Have you ever had ear surgery?	Right	Left	Both	No
Have you ever an ear injury?	Right	Left	Both	No
Have you ever had measles?			Yes	No
Have you ever had mumps?			Yes	No
Have you ever had kidney disease?			Yes	No
Have you ever had scarlet fever?			Yes	No
Have you ever had meningitis?			Yes	No
Do you have diabetes?			Yes	No
Do you have high blood pressure?			Yes	No
Do you have an existing hearing problem?			Yes	No
Do you have frequent ear infections?	Right	Left	Both	No
Do you shoot guns or hunt?			Yes	No
Do you wear a hearing aid?	Right	Left	Both	No
Do you participate in loud activities (music, motorcycle)?			Yes	No
Do you currently use prescriptions or over the counter drugs?			Yes	No
Are you currently suffering from allergies?			Yes	No
Does any of you immediate family have hearing problems?			Yes	No

Comment:

Do you have any other comments on the health of your hearing? _____

Examiner Only:

(Examiner Only) Patient has visible wax or object in ear.	Yes	No
(Examiner Only) Patient should be referred.		Yes

Authorization: The undersigned applicant or employee hereby authorizes Kettering Workers Care to disclose the Audiogram Test results to their employer.

Patient Signature

Audiogram Examiner Signature

_____/_____/_____
Date

_____/_____/_____
Date