Lawrence Speech & Hearing Services

Adult Hearing Questionnaire

Patient Name: _____

What brought you into our office today? _____

_____

	Yes	No
Have you ever had ear surgery?		
Do you have a history of ear infections?		
Do you have a family history of hearing loss?		
Do you have a history of noise exposure?		
Have you ever had any head trauma?		
Do you have ringing or roaring noises in your ears?		
Do you have dizziness, lightheadedness, or imbalance?		
Have you ever been treated with chemotherapy?		
Do you suffer from any serious illnesses?		

Please check the appropriate boxes below that apply to your current hearing abilities in various environments.

Select one: _____ With hearing aids _____ Without hearing aids

	How well do you currently hear in this environment?			How frequently are you in this listening environment?			
LISTENING ENVIRONMENTS	Well	Fair	Poor	Often	Sometimes	Rarely	Never
One-to One Conversations							
Quiet Room (1 to 2 people)							
Small Groups (4 to 6 people)							
Large Social Gatherings							
At the Work Place							
In Restaurants							
During Religious Services							
Meetings/Lectures							
In the Car							
Outdoors							
On the Telephone							
Watching Television							

Person completing form: _____
Relationship to patient: _____

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