

Mission Audiology
ADULT HEARING HEALTH PROFILE

Name _____ **Date** _____

1. Have you ever had your hearing tested before? yes no If yes, Where?

2. Do you have loss of hearing in one or both ears? Right ear Left Ear both
3. How long have you noticed hearing loss? less than 1 yr 1 or more 5 yrs or more
4. Have you had any surgery or medical problems with your ears? yes no _____
5. Please check any of the following that apply:
 Tinnitus (noise in ears), Vertigo/dizziness, Facial numbness/tingling, Pain in ears
 Sudden hearing loss, Ear infections/drainage, Noise exposure, Head Trauma
 Family history of hearing loss, History of headaches/migraines, other _____
6. Please check any of the following areas you have difficulty hearing:
 TV/Radio, quiet one on one conversations, Small/large groups, restaurants
 Telephone, In the car, Church/Synagogue, other _____
7. Have hearing aids been recommended to you? yes no
8. Are you currently using hearing aids? yes no
9. If yes, what type of hearing aids are you using? _____
10. Do you use your hearing aids several hours each day? yes no (If not, why not?)

11. Are you satisfied with your current hearing aids? yes no
12. If not satisfied, what don't you like about them? _____

Patient Signature

For internal use only
Patient specific needs:

Otосcopy: clear Cerumen Right left

1. _____ 2. _____
3. _____ 4. _____