SONARIS
EAR CENTER

HEARING HISTORY QUESTIONNAIRE

Name:	Date:

What is the primary reason for your visit? _____

HEARING HISTORY

	NO	YES
Do you have reduced hearing?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears When did it begin? _____ Did your reduced hearing occur gradually or suddenly? ☐ Gradually ☐ Suddenly What sort of difficulties is your reduced hearing causing for you? _____
Do you have ear pain?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears When did it begin? _____

AURAL (EAR) HEALTH

	NO	YES
Do you have ear fullness or feel plugged?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears
Have you had ear surgery?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears Reason for surgery: _____
Do you get frequent ear infections?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears When was your last ear infection? _____

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TINNITUS (EAR RINGING)		
	NO	**YES**
Do you get ringing in your ears?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears Describe what it sounds like: _____ When did it begin? _____
Does it pullsate like a heart beat?	☐	☐
Does it make it hard for you to fall asleep?	☐	☐
Does it wake you up from sleep?	☐	☐
Do you find it difficult to tolerate everyday sounds?	☐	☐
BALANCE		
	NO	**YES**
Do you get dizziness/vertigo	☐	☐ How frequently? _____ How long does it last? _____ What triggers it? _____ What effect does it have on your daily function? _____
Do you feel afraid you might fall?	☐	☐
NOISE EXPOSURE		
	NO	**YES**
Have you been exposed to loud noise either at work or elsewhere?	☐	☐ What kind of noise? _____

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	NO	YES
Do you have a heart condition?	☐	☐ Explain: _____
Do you have high blood pressure?	☐	☐
Are you diabetic?	☐	☐
Do you have any allergies?	☐	☐ What are you allergic to? _____
Do you take prescription medication?	☐	☐ For what? Please explain: _____
Do you smoke?	☐	☐
Do you consume alcohol?	☐	☐ How many glasses per week? _____

FAMILY HISTORY

	NO	YES
Did anyone in your family develop hearing loss before the age of 65 years?	☐	☐ Relation to you? _____

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AMPLIFICATION

	NO	YES
Have hearing aids ever been recommended for you?	☐	☐ Right Ear ☐ Left Ear ☐ Both Ears
Do you currently wear hearing aids?	☐	☐ What do you like **most** about your hearing aids? Explain: _____ _____ What do you like **least** about your hearing aids? Explain: _____ _____
If hearing aids can improve your hearing and you are not already wearing hearing aids, are you motivated to try them?	☐ Reason: _____ _____ _____ _____ _____	☐

If you already wear hearing aids, what would improve your hearing aid experience?

_____

_____

HEARING NEEDS

What are your top 3 most important hearing needs?

1. _____

2. _____

3. _____

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