Medical History (Continued)

Please circle any of the following that applies to you currently or in the past:

Head Injury Arthritis Cancer Diabetes High Blood Pressure Stroke

Bell's Palsy Headaches Meningitis Genetic Disorder

Audiological History

Will this be your first hearing test? Yes_____ No_____

Have you ever had ear surgery? Yes_____ No_____

Do you feel that you have a hearing loss? Yes_____ No_____

If yes, for how long? _____ Which is your better ear?_____

Do you have family history of hearing loss? Yes_____ No_____

Have you ever had earwax removed by a doctor? Yes_____ No_____

Hearing Aid History:

Do you currently wear hearing aid(s)? Yes_____ No_____

If yes, where were they purchased? _____

How old are they? _____ What brand are they? _____

How important is it for you to improve your hearing right now? Circle One

Not Important Somewhat Important Very Important