Home Audiology Services

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PATIENT INTERVIEW FORM

Patient Name: _____ Date: _____

1. Please describe the problem you are currently experiencing with your hearing:
   _____
   _____
   _____
2. How long have you been experiencing these difficulties? _____
3. Do these problems occur when you are:
   A. In a quiet environment _____ In a noisy environment _____
   B. In a one-on-one conversation _____ In a group conversation _____
   C. On the telephone _____
   D. Watching television _____
4. Does this problem affect one ear or both ears? _____
5. Is the decline in your hearing a gradual loss _____ or sudden loss _____
6. Is there any family history of hearing loss? _____
7. Is there any history of hearing aid use? _____
   If yes, please describe:
   _____
   _____
   _____
8. Are you experiencing tinnitus (ringing in the ears)? _____.
   IF YES:
   A. Is it affecting one ear or both ears? _____
   B. What is the frequency & duration? _____
   C. How long have you been experiencing it? _____
   D. Has there been a change in the intensity of the tinnitus? _____
9. Do you experience dizziness? _____
10. Do you experience frequent headaches? _____
11. Any history of head trauma? _____
12. Any history of ear surgery? _____
13. Describe any chronic health related issues you currently have (hypertension, diabetes, etc.):
    _____
    _____
14. Please list any medications you are currently taking: _____
    _____
    _____
15. Any history of noise exposure (job or recreational): _____
    _____