GN Audiology Hearing History

Name: _____ Date: _____ Phone No: _____

Date of Birth: _____ Email: _____

Address: _____

- Who referred you for this evaluation? _____
- How did you hear about us? _____
- What is your primary reason for this appointment? _____

  _____

Please **CIRCLE YES** or **NO**

- Have you had your hearing tested before? **YES** **NO**
- Do you have hearing loss in one or both ears? **YES** **NO**

  Please indicate Right, Left or Both Ears_____
- Have you worn hearing aids before? **YES** **NO**
- Does your hearing difficulty affect your daily life? **YES** **NO**
- Do you have pain or discomfort in your ears? **YES** **NO**
- Do you have any ringing or noises in your ears? **YES** **NO**
- Have you had any surgeries in your ears or do you have any drainage from your ears? **YES** **NO**
- Do you have any family history of hearing loss? **YES** **NO**
- Do you have any dizziness or vertigo? **YES** **NO**
- Do you have a history of noise exposure? **YES** **NO**
- Do you have a pacemaker? **YES** **NO**

Please list listening environments in which you would you like to hear better _____

_____