Lifestyle Questionnaire

Patient name: _____ Today's date: _____

Medical History

Reason for today's appointment: _____

Allergies to medications, plastics, etc.:_____

Current Medications: __**(PLEASE LIST ON THE SEPARATE MEDICATION FORM)**_____

Have you ever had ear surgery? Y / N If yes, which ear? R / L

Describe: _____

Please list all major surgeries (past 10 years):_____

Please list any serious illnesses (past 10 years):_____

Are you diabetic? Y / N

Hearing History

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

How long ago did you notice difficulties in your hearing?

Circle one: Recently 1-3 years 4-6 years 7-10 years More then 10 years

Have you ever used assistive listening devices? ..... Y / N

In which ear do you feel your hearing is poorer? ..... Right / Left Same

Which ear do you use on the telephone? …….. Right / Left Either

Have you experienced sudden or progressive hearing loss within the last 90 days?..... Right / Left Both Neither

Have you experienced any drainage from your ear(s) within the last 90 days? Right / Left Both Neither

Do you suffer from pain or discomfort in your ear(s)? ..... Right / Left Both Neither

Do you suffer from acute or chronic dizziness? ..... Y / N

Hearing Assessment

1. Do you feel that people are mumbling or not speaking clearly? …….. Y / N

2. Do you find yourself asking people to speak up or repeat themselves? …… Y / N

3. Do you find men's voices easier to understand than voices of woman or children? ..... Y / N

4. Do you experience difficulty understanding soft or whispered speech? …… Y / N

5. Do you have difficulty understanding speech on the telephone? …… Y / N

6. Does difficulty with hearing cause you to visit friends, relatives or neighbors less often than you would like?..... Y / N

7. Do you experience ringing or noises in your ears? …… Y / N

8. Do you find it difficult to understand a speaker at a public meeting or religious service? …… Y / N

9. Do you find it difficult to follow a conversation in a noisy or crowded room? …….. Y / N

10. Do you spend time in loud environments (concerts, sporting events etc.) where you need to hear in the presence of background noise?..... Y / N

11. Do you attend work or social meetings where you need to be able to communicate amidst group conversation?..... Y / N

12. Are you actively working or need to communicate with people throughout the day? ..... Y / N

Listening Environment Rating

Please provide the top three listening situations where you would like to hear better.

1. _____

2. _____

3. _____

Lifestyle Considerations

Circle those that apply:

1. What factors are important to you?

Cosmetics
Handling/ dexterity
Price
Ease of use/automatic

2. What types of phone(s) do you usually use?

Desk or Wall
Speaker or Handset
Mobile

3. Which of the following best describes your living environment?

Assisted Retirement Community
Independent Retirement Community
Live Alone
Live with family
Have pets