HEARING PROFILE

NAME: _____ DATE: _____

(circle the best answer)
How long have you noticed your hearing loss? <90 days <1 year >1 year

Is your hearing loss in one ear or both ears? Right Left Both Not Sure

Do you have ringing / noises in your ears? Yes No

Do you have vertigo (spinning)? Yes No
If Yes, when was your last episode? _____

Do you have dizziness/unsteadiness? Yes No
If Yes, how often? _____

Have you had any medical problems or surgeries related to your ears? Yes No

Explain: _____

Is there a history of hearing loss in your family? Yes No

Have you been exposed to loud noises? Yes No

Explain: _____

Circle the difficult listening situations for which you would like improvement:

TV/Radio	In the Car	Quiet One-on-One
Small Groups	Phone	Church / Synagogue
Large Groups	Restaurants	Other: _____

Have others suggested you have a hearing problem? Yes No

How does this make you feel? _____

Are you ready to receive help for your hearing loss? Yes No

Do you currently wear hearing aids? Right Left No

If Yes, what kind? _____

Are you satisfied with your current hearing aids? Yes No

If No, what area(s) would you like improvement? _____