

First name (legal) Middle Initial Last name Preferred name

Please choose **YES** or **NO** to the following questions

Are you experiencing hearing difficulties?
 If yes, how long?
 How would you describe your hearing difficulties?

Do you feel one ear is worse than the other?
 If yes, which one?

Have you ever worn hearing aids?
 If yes, for how long?

Do you hear sounds in your ears lasting longer than 2 minutes?
 (think ringing, buzzing, humming, hissing, etc.)
 If yes, which ear?

Have you been exposed to loud noises?
 (loud music, gunfire, military, occupational/work exposure, etc.)

Do you have a family history of hearing loss?

Have you had any changes in prescription medications in the past 6 months?

Have you had any concerns about your memory?
 If yes, have you discussed it with your primary physician?

Have you experienced any of the following:

Sudden changes in hearing	Dizziness/vertigo	History of stroke/TIA
Ear pain	Head injury	History of cancer
Ear pressure/fullness	Heart problems	History of tobacco use
Ear drainage	Diabetes	Allergies/sinus issues
Ear surgeries	High blood pressure	Neurological problems

Additional comments