UCLA Health | it begins with U

UCLA AUDIOLOGY CLINIC

Name: _____

What is the reason for your visit today?

Please circle your answers to the following questions. Thank you.

1. Do you have a problem with your hearing? YES NO

   If YES, which ear? RIGHT LEFT BOTH

2. Do you have tinnitus (ringing, buzzing or any other sound in your ear)? YES NO

   If YES, which ear? RIGHT LEFT BOTH

3. Have you ever had ear surgery? YES NO

   If YES, which ear? RIGHT LEFT BOTH

   What kind of surgery?

4. Have you had an ear infection within the past 3 months? YES NO

   If YES, which ear? RIGHT LEFT BOTH

5. Do you have ear pain? YES NO

   If YES, which ear? RIGHT LEFT BOTH

6. Have you ever had significant noise exposure? YES NO

   If so, what type of noise?
   Did you wear hearing protection?

7. Do you currently wear, or have you previously, worn hearing aids? YES NO

   If YES, which ear? RIGHT LEFT BOTH
   If YES, what brand and type of hearing aids?

8. Are you experiencing dizziness? YES NO