TEXAS HEARING CLINIC

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Veterans Evaluation Services: History

Patient Name: _____DOB:_____ Date:_____ Gender: o M o F
Dates of Military Service:_____

Current Symptoms:

Do you feel that you have a hearing loss? o Yes o No

If yes, do you have difficulty in the following situations?

- o Place of employment
- o One on one (quiet conversation)
- o Small groups
- o Noisy restaurants

Do you have a better ear? o Left o Right o Equal

Do you wear hearing aids? o Yes o No

Do you hear noises in your ears? o Yes o No

If yes, describe the sound:_____

How long have you noticed this sound?_____

Does the noise stop you from focusing at work or home? o Yes o No

Is the noise bothersome? o Yes o No

Noise History:

Before your military service, did you have any exposure to noise? o Yes o No

If yes, please describe:_____

While in the military, were you exposed to high noise environments? o Yes o No

If yes, please describe:_____

After discharge from the military, have you had noise exposure? o Yes o No

If yes, please describe:_____