



Name: _____ Birth Date: _____ Chart #: _____

Today's Date: _____

Visual and Hearing Loss Questionnaire

VISION (WITH GLASSES ON)

Do you have difficulty with the following activities because of your decreased vision?

Circle One

- Driving during the day?
- Driving at night?
- Reading the telephone book or dialing a telephone?
- Reading labels?
- Reading books or newspapers?
- Recognizing people when they are close to you?
- Seeing steps, stairs or curbs?
- Doing fine handiwork such as sewing or knitting?
- Enjoying hobbies like crafts or carpentry?
- Filling out forms?
- Playing games such as bingo, dominos or cards?
- Taking part in sports like tennis or golf?
- Cooking or preparing meals?
- Watching television?
- Working at a job?

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

HEARING

- Do you currently wear hearing aids? If so, how old are they? _____
- Have you ever been told you have hearing loss?
- Do you have difficulty understanding conversations when in groups or noisy situations?
- Do others complain that you watch television with the volume too high?
- Is it hard to understand when you can't see the speaker's face?
- Do others tell you that you talk too loud?
- Do you frequently have to ask others to repeat themselves?
- Have you experienced a sudden loss of hearing in the past 90 days?
- Have you ever experienced tinnitus or ringing in your ears?
- Do people around you seem to mumble?
- Do you have trouble hearing on the telephone?
- Do you have trouble hearing common sounds like turn signals and doorbells?
- Do you have a history of drainage or heavy wax production in your ear?
- Have you ever had medical treatment or surgery on either ear?

Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No
Yes	No

Doctor Signature: _____

Date: _____