Hearing Health Services

Date:_____ **Name:**_____

Reason for today's visit:_____

1. Have you experienced any of the following conditions? If YES, briefly explain.

❒Chronic Ear Infections	❒Deformity of the ears	❒One-sided Hearing Loss	❒Sound Sensitivity
❒Meniere's Disease	❒Visual Problems	❒Sinus Problems	❒Diabetes
❒High/Low Blood Pressure	❒Heart Condition	❒Stroke	❒Head Trauma
❒Cancer/Cancer Treatment	❒Kidney Disease	❒Genetic Disorders	❒Liver Disease
❒Anemia/Blood Disorders	❒Nervousness/Anxiety	❒Depression	❒ Dizziness
❒Alzheimer's/Dementia	❒Allergies (List):_____		

Comments:_____

2. Are you are currently a smoker? ❒Yes ❒No If yes, how many years?_____

3. Have you fallen at all in the last 24 months? ❒Yes ❒No If yes, how many times? _____

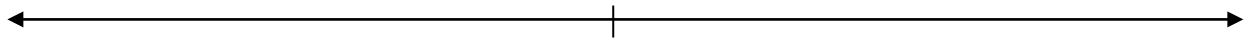
4. Do you think you have a hearing problem? ❒Yes ❒No
   If yes, how long have you noticed the problem: _____
   Was the onset: ❒Sudden ❒Gradual
   Which ear is poorer: ❒Left ❒Right ❒Unsure
   Does your hearing remain:❒ Constant ❒Fluctuate
   Has your hearing become worse since you first noticed the problem: ❒Yes ❒No ❒Unsure

5. Do you currently have **difficulty** hearing or understanding any of the following?

❒Watching TV	❒Using the telephone	❒One on one conversations	❒Doorbell/knocking
❒Restaurants	❒At the movies	❒Worship Service	❒Telephone ring
❒Crowds	❒Fire/smoke detector	❒Sirens	❒Alarm clock

❒Other (List):_____

6. How important is it for you to improve how you hear, understand, or communicate with others **RIGHT NOW**: (mark on the line)



0 (Not at all important) (Extremely important) 10

7. Have you had your hearing tested before? ❒Yes ❒No If yes, when and where:_____

8. Have you had any drainage from the ear within the past 90 days? ❒Yes ❒No

9. Have you experienced any dizziness, vertigo or balance problems? ❒Yes ❒No

10. Have you had any pain/discomfort in your ears with the past 90 days: ❒Yes ❒No

11. Do you have any noises or ringing in your ears? ❒Yes ❒No Left ear/ Right ear/ Both
    If present, is it: ❒Constant ❒Intermittent When did you first notice it? _____

12. Have you been exposed to loud noises? (Employment, Military, Recreation, etc.) ❒Yes ❒No
    If yes, describe the type of noise: _____

13. Have you seen or had ear surgery by an ENT? ❒Yes ❒No
    If yes, please explain: _____

14. Have you seen your primary doctor in the past 6 months? ❒Yes ❒No
    If yes, who: _____

15. Have you ever seen a doctor for wax removal? ❒Yes ❒No When: _____

16. Does anyone in your family have hearing loss? (ex: parents, siblings, etc.) ❒Yes ❒No

18. Have you ever worn hearing instruments? ❒Yes ❒No
    If yes, how would you rate your experience with your hearing aids?

    _____

    0 (Unsatisfactory) (Great) 10

19. Select all that apply:
    ❒I have been thinking that I might need hearing aids.
    ❒I have started to seek information about hearing aids.
    ❒I am ready to wear hearing aids if they are recommended.
    ❒I currently wear hearing aids.

Comments or questions for the audiologist: _____

I have reviewed the above information to be true and accurate. All information obtained will remain completely confidential.

Signature _____