Hearing Health Assessment

Date:___/___/ 20___

Patient Name: ___________________________ D.O.B. ____/____/___ AGE: _________

Reason for today's visit:____

When was your last hearing exam? ____

What were the recommendations? ____

How long ago did you notice a decline in your hearing?

○ Within the past 90 days ○ 1-3 years ○ 4-6 years ○ 10+ years

Have you ever used an assistive listening device? ○ No ○ Yes ______________________

Do you suffer from acute or chronic dizziness? ○ No ○ Yes ______________________

History of ear infections? ○ No ○ Yes ______________________

Frequent headaches? ○ No ○ Yes ______________________

Head trauma? ○ No ○ Yes

Temporalmandibular joint (TMJ) disorder? ○ No ○ Yes

Are you or were you ever exposed to loud sounds? ○ No ○ Yes(military, construction, concerts, power tools, etc)

If yes, please explain: ____

Tinnitus (Ringing in the ear or head noises) ○ No ○ Yes If yes: ○Right ○Left ○Inside Head

____

____

Do sounds cause you physical discomfort? ○ No ○ Yes __________________________________

History of hearing loss in the family? ○ No ○ Yes __________________________________

Have you ever had ear surgery? ○ No ○ Yes If yes, which ear? ○ Right ○ Left

Type of surgery: ____

Do you have regular MRI's? ○ No ○ Yes __________________________________

Please list your current medications. Use back page if necessary:

Medication:______________________For:___________________________Since:________________

Medication:______________________For:___________________________Since:________________

Medication:______________________For:___________________________Since:________________

Medication:______________________For:___________________________Since:________________

Allergies to any medications, plastics, etc…? ____

Please list all major surgeries and illness (past 10 years) ________________________________

____

____

How would you rate your hearing on a scale of 1 to 10 (with 1 being the worst and 10 being the best)? ____________________________________

Does a hearing problem	**Frequently**	**Sometimes**	**Rarely**
Make it difficult for you to converse on the telephone?	F	S	R
Cause others to complain that you turn up the television or radio too loud?	F	S	R
Cause you difficulty following conversation in a restaurant?	F	S	R
Limit or hamper your personal or social life?	F	S	R
Cause you to have to ask people to repeat themselves?	F	S	R
Cause you to have difficulty hearing when you are in the presence of background noise?	F	S	R
Cause you to have difficulty hearing women's or children voices?	F	S	R
Cause you to hear people speak, but fail to understand what they are saying?	F	S	R
Cause you to feel as though others mumble?	F	S	R
Cause you to feel stressed or tired when listening for long periods of time?	F	S	R

Please provide the top three listening situations where you would like to hear better

1. ____
2. ____
3. ____

Please select your current lifestyle, and, if different, please identify your desired lifestyle

(Use the lifestyle chart in your guidebook for assistance and examples)

Active Lifestyle (Frequent Background Noise) ○ Current ○ Desired

Casual Lifestyle (Occasional Background Noise) ○ Current ○ Desired

Quiet Lifestyle (Limited Background Noise) ○ Current ○ Desired

Very Quiet Lifestyle (Rare Background Noise) ○ Current ○ Desired

NOTES:____

____

____

____