

Hearing Health Assessment

TO BE COMPLETED BY PATIENT

Patient Name _____ Sex M F Date ____/____/____
First MI Last MM DD YYYY

How did you find out about us?

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What would you like to accomplish at today's appointment? _____

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing? Within 1 Year 1-5 Years 6-10 Years 10+ Years

Have you ever utilized hearing devices? Yes No If yes, describe your satisfaction _____

Which ear do you most often use on the telephone? R L Both Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? R L Both Neither

Have you ever had ear surgery? Yes No If yes, when: _____ Which ear: _____ Name of procedure: _____

Do you suffer from pain or discomfort in your ears? Yes No Have you had chronic ear infections? Yes No

Do your ears produce a significant amount of wax? Yes No Have you ever had any trauma to the head? Yes No

Are you experiencing any pressure in your ears? Yes No Do you suffer from dizziness? Yes No

Do you suffer from tinnitus (ringing in the ears)? Yes No Do you have a family history of hearing loss? Yes No

Are you currently using any medications? Yes No

If yes, please list _____

Do you have a history of any of the following? Measles Mumps Diabetes Pneumonia

Frequent Headaches High Fevers Meningitis Other (describe) _____

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

Workplace Military Firearms Music Motorcycles Lawn Mower Other (describe) _____

Patient dexterity Good Fair Poor Patient vision Good Fair Poor

Are there any specific features you are interested in for your hearing solution? _____

