Adult Hearing Health Assessment

Patient Name _____ Date _____ DOB _____

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient _____

☐ Advertisement ☐ Insurance ☐ Referred by Physician _____

☐ Consumer Seminar ☐ Employer ☐ Other _____

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 significant wax? ☐ Yes ☐ No

Have you 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

Any family history of hearing loss? ☐ Yes ☐ No

Are you currently using any medications? ☐ Yes ☐ No

If yes, please list medications, dosage & how it' s taken

_____

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

Please check all medical symptoms that apply:

_____ High Blood Pressure

_____ Nose, Throat, or Mouth Problems

_____ Cardiovascular Problems

_____ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)

_____ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness)

_____ Psychiatric Issues (such as depression, anxiety, compulsions)

_____ Kidney Problems

_____ Hematologic/Lymphatic Symptoms (such as bleeding gums, bruising)

_____ Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency)

_____ Smoke / If so, how often? _____ Did you quit over 1 year ago? Yes / No

_____ Exposed to Second Hand Smoke

_____ Alcohol ____ Daily ____ Weekly ____ Occasionally

_____ Caffeine

_____ Stroke

_____ Cancer

_____ Have you fallen within the past year? If so, how many times? _____ With injury? _____

Does a hearing problem cause you to feel embarrassed when you meet new people?
Yes Sometimes No

Does a hearing problem cause you to feel frustrated when talking to members of your family?
Yes Sometimes No

Do you have difficulty when someone speaks in a whisper?
Yes Sometimes No

Do you feel handicapped by a hearing problem?
Yes Sometimes No

Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
Yes Sometimes No

Does a hearing problem cause you to attend religious services less often than you would like?
Yes Sometimes No

Does a hearing problem cause you to have arguments with family members?
Yes Sometimes No

Does a hearing problem cause you difficulty when listening to TV or radio?
Yes Sometimes No

Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
Yes Sometimes No

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
Yes Sometimes No

Please check off all boxes where you would like to hear better

- ☐ Quiet Conversation
- ☐ Doorbell
- ☐ Phone Ringing
- ☐ Alarms (Clock, Security, Timers, etc.)
- ☐ Home Telephone
- ☐ Driving
- ☐ Religious Services
- ☐ Adult Conversations
- ☐ Small Family Gatherings
- ☐ Quiet Restaurants
- ☐ Cellphones
- ☐ Shopping
- ☐ Movie Theaters
- ☐ Health Clubs
- ☐ Small Group Meetings
- ☐ Conversations with Children
- ☐ Television
- ☐ Open/Reverberant Home
- ☐ iPod®/Personal Music Players
- ☐ Outdoor Activities
- ☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)
- ☐ Busy Restaurants
- ☐ Frequent Social Gatherings
- ☐ Smartphones
- ☐ Conference Calls
- ☐ Multimedia Connectivity (Home Theater, Computer, Phone, etc.)
- ☐ Travel & Airports
- ☐ Concerts & Arts
- ☐ Group Presentations

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic **Does the companion agree?** ☐ Yes ☐ No

What are the top three environments in which you would like to hear better?

1. _____ _____ _____ _____
2. _____ _____ _____ _____
3. _____ _____ _____ _____

Please add any additional information here:

_____

_____

_____

_____

_____

_____

_____