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 _____

Temporal mandibular joint (TMJ) disorder? ○ No ○ Yes _____

Are you or were you ever exposed to loud sounds? ○ No ○ Yes _____

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

_____

_____

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

Is there a history of hearing loss in the family? ○ No ○ Yes _____

Have you ever had ear surgery? ○ No ○ Yes ○ 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 too loud?	F	S	R
Cause you difficulty following conversations 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 difficulty understanding in the presence of background noise?	F	S	R
Cause you difficulty hearing women's or children voices?	F	S	R
Cause you to hear people speak, but not understand what's said?	F	S	R
Cause you to feel as though others mumble?	F	S	R
Cause you to feel stressed/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

Active Lifestyle (Frequently around Background Noise)	○ Current	○ Desired
Casual Lifestyle (Occasionally around Background Noise)	○ Current	○ Desired
Quiet Lifestyle (Rarely around Background Noise)	○ Current	○ Desired
Very Quiet Lifestyle (Never around Background Noise)	○ Current	○ Desired

NOTES:_____
_____
_____
_____