



Hearing Health Assessment

New Patients

Patient Name: _____ Date: _____

Medical History

Reason for today's appointment: _____

Allergies to any medications, plastics etc.? _____

Current medications: _____

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

Type: _____

Please list all major surgeries: _____

(Past 10 years) _____

Please list any serious illnesses: _____

(Past 10 years) _____

Are you diabetic? Yes No

General History

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

What were the recommendations? _____

How long ago did you notice a decline in your hearing? Recently 1 – 3 yrs 4 – 6 yrs 7 – 10 yrs 10+ yrs

Have you ever used assistive listening devices? Yes No

In which ear is your hearing poorest? Right Left Same

Which ear do you use on the telephone? Right Left Same

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

Have you experienced any drainage from your ear(s) within the last 90 days? R L Both Neither

Do you suffer from pain or discomfort in your ear(s)? R L Both Neither

Do you suffer from acute or chronic dizziness? Yes No

Is there visible congenital or traumatic deformity of the ear? Yes No

Do you experience tinnitus (ringing in the ears)? Yes No

Describe: _____



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Does a hearing problem...

	Always	Sometimes	Never
Cause you to feel embarrassed or uncomfortable when meeting new people?	1	2	3
Cause you to feel frustrated when talking to members of the family?	1	2	3
Make it difficult for you to converse on the telephone?	1	2	3
Cause you difficulty following conversations in a restaurant?	1	2	3
Cause you to have to ask people to repeat themselves?	1	2	3
Cause you to have difficulty hearing in the presence of background noise?	1	2	3
Cause you to have difficulty hearing women's or children's voices?	1	2	3
Cause you to feel as though others mumble?	1	2	3
Cause you to attend religious or social functions less than you would like?	1	2	3
Cause you to have arguments with family or friends?	1	2	3
Cause you to feel stressed or tired when listening for long periods of time?	1	2	3
Cause others to complain that you turn up the television or radio too loud?	1	2	3
Limit or hamper your personal or social life?	1	2	3
Cause you to hear people speak but fail to understand what they are saying?	1	2	3

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 (Frequent Background Noise)

Current Desired

Quiet Lifestyle (Limited Background Noise)

Current Desired

Casual Lifestyle (Occasional Background Noise)

Current Desired

Very Quiet Lifestyle (Rare Background Noise)

Current Desired

Notes: _____
