Hearing Health Assessment

New Patients

Patient Name _____ Date _____

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?

○ Within past 90 days ○ 1–3 years ○ 4–6 years ○ 7–10 years ○ 10+ years

Has anyone in your family suffered hearing loss? ○ Yes ○ No If yes, who? _____

Have you fallen in the past year? ○ Yes ○ No

Have you ever used Tobacco products? ○ Yes ○ No If yes, when & for how long? _____

Medical History

○ Multiple Sclerosis	○ Radiation therapy to local area	○ Compromised immune system
○ Cancer	○ Coronary Heart Disease	○ High Blood Pressure
○ Cognitive ability	○ Chemotherapy within 6 months	○ TMJ
○ Regular MRI's	○ Sudden Hearing Loss	○ Head Injury
○ Diabetes	○ Family history of diabetes? If yes, who? _____	

Cognition may be impacted by hearing; would you like to test your memory & brain health? ○ Yes ○ No

Allergies to any medications, plastics, etc.? _____

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

Type _____

Please list all major surgeries, illnesses and other medical conditions: _____

_____

For AuD. Use Only

		Right Ear	Left Ear
InTERvIEw	Patient Experience	○ Poor hearing ○ Telephone ○ Ringing ○ Pain/discomfort ○ Drainage (past 90 days) ○ Excessive noise exposure	○ Poor hearing ○ Telephone ○ Ringing ○ Pain/discomfort ○ Drainage (past 90 days) ○ Excessive noise exposure

Notes _____

_____

_____

_____

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Device History

Are you a current HA wearer? ○ Yes ○ No If Yes, for how long?_____

What do you like about your current devices? _____

_____

What upgrades would you like in new devices? ○ Rechargeable ○ Direct streaming to cell phone

○ Other: _____

Does a hearing problem

	Always	Sometimes	Never
Make it difficult for you to converse on the telephone? ○ Landline ○ Cell Phone - iPhone or Android	A	S	N
Cause others to complain that you turn up the television or radio too loud?	A	S	N
Cause you difficulty following conversation in a restaurant?	A	S	N
Limit or hamper you from doing the things you enjoy doing?	A	S	N
Cause you to have to ask people to repeat themselves?	A	S	N
Cause you to have difficulty hearing when you are in the presence of background noise?	A	S	N
Cause you to have difficulty hearing women's or children's voices?	A	S	N
Cause you to hear people speak, but fail to understand what they are saying?	A	S	N
Cause you to feel as though others mumble?	A	S	N
Cause you to feel stressed or tired when listening for long periods of time?	A	S	N

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

1. _____
2. _____
3. _____

Please select your current lifestyle, and your desired lifestyle:

Very Quiet

Rare Background Noise

○ Current
○ Desired

Quiet

Limited Background Noise

○ Current
○ Desired

Casual

Occasional Background Noise

○ Current
○ Desired

Active

Frequent Background Noise

○ Current
○ Desired