



Hearing Specialists

A Professional Approach to Hearing Better

Name: _____ Age: _____ Date: _____

Occupation (current or past): _____

Primary Concern

- Hearing Loss, Difficulty Hearing, Tinnitus/ringing, Balance, Right Ear, Left Ear, Both ears, In Quiet, In Noise, On the phone, Right ear, Left Ear, Both, Constant, Intermittent, Off Balance, Vertigo, Lightheaded

Other: _____

How long have you had these concerns: _____

Medical History

Yes No

- Will this be your first hearing test? If no, when and where was last test?
Have you ever had ear surgery? If yes, please explain:
Is this a work related injury or exposure? If yes, date of injury or exposure
Please explain:
Do you have a known deformity of the ear? If yes, explain:
Did you experience a sudden change in hearing? If yes explain:
Do you ever have ear pain? If yes, explain
Do you ever experience dizziness/ light headedness? If yes,
Has a doctor ever had to remove wax from your ear? If yes, when
Is there a history of hearing loss in your family? If yes, who:
Is the cause of hearing loss known? If yes, what is the cause:

Please check any of the following medical conditions that you have or have had in the past:

- Arthritis, Asthma, Bell's Palsy, Cancer, CMV, Diabetes, Neurological Disease, Heart Conditions, Measles or Mumps, High Blood Pressure, HIV or AIDS, Hepatitis, Meningitis, Head Injury, Parkinson's, Scarlet Fever, Sinusitis, Stroke/TIA, Vision Loss, Meniere's Disease

Please provide the medications that you are currently taking on a regular basis.

- Medication _____ For _____ Since _____
Medication _____ For _____ Since _____
Medication _____ For _____ Since _____
Medication _____ For _____ Since _____
Medication _____ For _____ Since _____

Have you ever been exposed to loud noise, either currently or in the past? YES NO

If yes, what type:

- Farm machinery, Factory Noise, Jet Engines, Music, Power Tools, Military, Hunting/shooting, Ports, Other:

HEARING HISTORY

Without Hearing Aids			If applicable With Hearing Aids	
Yes	No		Yes	No
___	___	Do you find yourself asking people to repeat what they have said?	___	___
___	___	Do you sometimes hear the words without understanding them?	___	___
___	___	Do you have more difficulty hearing if you cannot see the speaker?	___	___
___	___	Do you have more difficulty hearing because of background noise?	___	___
___	___	Do others complain that the TV is too loud?	___	___

LISTENING SITUATIONS

In which situations would you like to hear better? *Check all that apply.*

- | | | | |
|------------------------------|------------------|---------------------|------------------|
| ___ One on One Conversations | ___ Large Groups | ___ Workplace | ___ Small Groups |
| ___ Religious Service | ___ Car | ___ Meetings | ___ Television |
| ___ Meetings | ___ Outdoors | ___ Movies/theatres | ___ Telephone |
| ___ Other | | | |

HEARING PREFERENCES AND EXPECTATIONS

- | | | | | |
|---------------------|--------------------|------------------------|-------------|-----------------|
| Hearing in Quiet | ___ Very Important | ___ Slightly Important | ___ Neutral | ___ Unimportant |
| Hearing in Noise | ___ Very Important | ___ Slightly Important | ___ Neutral | ___ Unimportant |
| HearingAidExpense | ___ Very Important | ___ Slightly Important | ___ Neutral | ___ Unimportant |
| Cosmetic Appearance | ___ Very Important | ___ Slightly Important | ___ Neutral | ___ Unimportant |

How confident are you in your knowledge regarding hearing aid technology?

- ___ Very Confident ___ somewhat confident ___ Neutral ___ Not Confident

How much benefit do you expect to gain from hearing aids?

- ___ Significant Benefit ___ Moderate Benefit ___ Neutral ___ No Benefit

How motivated are you to wear hearing aids?

- ___ Highly Motivated ___ Slightly Motivated ___ Neutral ___ Not Motivated

How confident are you that you will be successful with hearing aids?

- ___ Very Confident ___ Somewhat Confident ___ Neutral ___ Not Confident

HEARING AID PREFERENCES

Would you prefer hearing aids that:

- ___ Are completely automatic so that you do not have to make any adjustments
- ___ Allow you to adjust the volume and make program selections as needed
- ___ Not sure or no preference

If results show that hearing aids would be beneficial, are you ready to try amplification?

Please rate your readiness on this 1 -10 scale

- Not Ready 1 2 3 4 5 6 7 8 9 10 Very Ready

CURRENT HEARING AID USERS

How long have you worn hearing aids? _____ Do you wear one or two? _____

How old are your current hearing aids? _____ How often do you wear your hearing aids? _____

What do you like about your hearing aids? _____

What would you want to improve about your hearing aids? _____