



## Health Hearing Assessment

If someone besides the patient is completing this form;

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Patient Name \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
First MI Last mm dd yy

Specifically, how can we help you? \_\_\_\_\_

How long has it been since your last hearing test? \_\_\_\_\_

### **MEDICAL: Internal Use Only**

RX Dizzy Diabetes Tobacco Fall/Risk Communication Tinnitus

Tinnitus: On a scale of 1-10, how do you rate your tinnitus? \_\_\_\_\_

Dizziness: On a scale of 1-10, how do you rate your balance? \_\_\_\_\_

Communication: On a scale of 1-10, how do you rate your ability to communicate? \_\_\_\_\_

### **COMMUNICATION**

Often Sometimes Rarely

#### *Self-Questionnaire: Does a hearing problem:*

- Cause you to have to ask people to repeat themselves?  Often  Sometimes  Rarely
- Does your hearing cause you to feel frustrated when talking to family members?  Often  Sometimes  Rarely
- Does your hearing cause you to attend religious services less often?  Often  Sometimes  Rarely
- Cause you to have difficulty hearing women's/children's voices?  Often  Sometimes  Rarely
- Make it difficult for you to converse on the telephone?  Often  Sometimes  Rarely
- Cause others to complain that you turn up the television/radio too loud?  Often  Sometimes  Rarely
- Cause you to have difficulty following conversations in a restaurant?  Often  Sometimes  Rarely
- Cause difficulty hearing when in the presence of background noise?  Often  Sometimes  Rarely
- Cause you to hear people speak but fail to understand what all they are saying?  Often  Sometimes  Rarely
- Cause you to feel as though others mumble?  Often  Sometimes  Rarely
- Cause you to feel stressed or tired when listening for long periods of time?  Often  Sometimes  Rarely

Please tell us where you would like to hear better?

1.
2.
3.

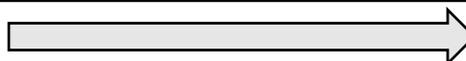
Current, and if different, **desired** lifestyle Current/Desired

Active lifestyle (frequent background noise)

Casual Lifestyle (occasional background noise)

Very Quiet Lifestyle (Rare background noise)

Please fill out your medical history on the back of this page...



## Medical History

### Hearing Device History

	Yes	No	
Have hearing devices ever been recommended?	<input type="checkbox"/>	<input type="checkbox"/>	
Have you ever worn a hearing device?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you wear one now?			Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/>
Do you perceive benefit with your hearing device(s)?	<input type="checkbox"/>	<input type="checkbox"/>	
Is there a family history of hearing loss? (prior to age 30)	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, who? _____			
Earaches or drainage in the past 90 days?	<input type="checkbox"/>	<input type="checkbox"/>	
Medical/surgical treatment for your ears?	<input type="checkbox"/>	<input type="checkbox"/>	
Any dizziness (spinning, unsteady, lightheaded)?	<input type="checkbox"/>	<input type="checkbox"/>	
Do you notice any tinnitus (ringing, buzzing, roaring)?	<input type="checkbox"/>	<input type="checkbox"/>	
If Yes, which ear? _____			Left <input type="checkbox"/> Right <input type="checkbox"/> Both <input type="checkbox"/> Can't Tell <input type="checkbox"/>
Is it bothersome?	<input type="checkbox"/>	<input type="checkbox"/>	
How frequently? _____			Rarely <input type="checkbox"/> Occasionally <input type="checkbox"/> Daily <input type="checkbox"/> Constant <input type="checkbox"/>
Please describe what you hear: _____			

History of ear infections?	<input type="checkbox"/>	<input type="checkbox"/>	
History of ear pain?	<input type="checkbox"/>	<input type="checkbox"/>	
History of aural fullness (pressure in ears)?	<input type="checkbox"/>	<input type="checkbox"/>	
History of loud noise-recreationally or occupational?	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/> Firearms	<input type="checkbox"/> Factory Work	<input type="checkbox"/> Military Equipment	<input type="checkbox"/> Power tools
<input type="checkbox"/> Loud Music	<input type="checkbox"/> Explosions	<input type="checkbox"/> Heavy Equipment	<input type="checkbox"/> Farm Equipment
<input type="checkbox"/> Motorcycles/recreational Vehicles	Other: _____		

### Have you ever had any of the following?

<input type="checkbox"/> Arthritis	<input type="checkbox"/> Depression	<input type="checkbox"/> High Fevers Mumps	<input type="checkbox"/> Multiple Sclerosis
<input type="checkbox"/> Allergies	<input type="checkbox"/> Dementia	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Headaches	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Parkinson's
<input type="checkbox"/> Bell's Palsy	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Kidney/Renal	<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Meningitis	<input type="checkbox"/> Vascular Problems

Other: \_\_\_\_\_

**Current Blood Thinner Medication:** \_\_\_\_\_