BRIDGE HEARING CENTER

Understanding matters. Bridge the gap.

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

Self-Questionnaire: Does a hearing problem:

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

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?	☐	☐
Have you ever worn a hearing device?	☐	☐
Do you wear one now? Left ☐ Right ☐ Both	☐	☐
Do you perceive benefit with your hearing device(s)?	☐	☐
Is there a family history of hearing loss? (prior to age 30)	☐	☐

If Yes, who? _____

Earaches or drainage in the past 90 days?	☐	☐
Medical/surgical treatment for your ears?	☐	☐
Any dizziness (spinning, unsteady, lightheaded)?	☐	☐
Do you notice any tinnitus (ringing, buzzing, roaring)?	☐	☐

If Yes, which ear? Left ☐ Right ☐ Both ☐ Can't Tell ☐

Is it bothersome?	☐	☐

How frequently? Rarely ☐ Occasionally ☐ Daily ☐ Constant ☐

Please describe what you hear: _____

History of ear infections?	☐	☐
History of ear pain?	☐	☐
History of aural fullness (pressure in ears)?	☐	☐
History of loud noise-recreationally or occupational?	☐	☐

☐ Firearms ☐ Factory Work ☐ Military Equipment ☐ Power tools

☐ Loud Music ☐ Explosions ☐ Heavy Equipment ☐ Farm Equipment

☐ Motorcycles/recreational Vehicles Other: _____

Have you ever had any of the following?

☐ Arthritis ☐ Depression ☐ High Fevers Mumps ☐ Multiple Sclerosis

☐ Allergies ☐ Dementia ☐ HIV/AIDS ☐ Pacemaker

☐ Anxiety ☐ Headaches ☐ Hyperthyroidism ☐ Parkinson's

☐ Bell's Palsy ☐ Head Trauma ☐ Hypothyroidism ☐ Seizures

☐ Cancer ☐ Hepatitis ☐ Kidney/Renal ☐ Stroke/TIA

☐ Diabetes ☐ High Blood Pressure ☐ Meningitis ☐ Vascular Problems

Other: _____

Current Blood Thinner Medication:_____