

# Hearing Health Assessment

## New User



Name \_\_\_\_\_

In our professional experience, we have found that many of our patients describe hearing loss as the lack of clarity or a moment lacking in hearing or understanding. This affects not only their normal daily routines, but the lives of those around them. We would like to ask you a few situational questions to better understand your hearing environment and how we might improve your quality of life.

	Frequently	Sometimes	Rarely
When using the telephone, how often are you experiencing difficulty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When watching television, how often are you experiencing difficulty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When in restaurants, how often are you experiencing difficulty?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is your hearing limiting or hampering your social life?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you ask someone to repeat themselves?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When in the presence of background noise, how often are you experiencing a lack of clarity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
When listening to women's or children's voices, how often are you experiencing a lack of clarity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you hear people speak but not understand what they are saying?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often do you feel as though other people are mumbling?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often is your hearing causing you to feel stressed or tired after listening for long periods of time?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

- |                                |                                  |                                   |
|--------------------------------|----------------------------------|-----------------------------------|
| <input type="radio"/> Driving  | <input type="radio"/> Outdoors   | <input type="radio"/> Telephone   |
| <input type="radio"/> Family   | <input type="radio"/> Religious  | <input type="radio"/> Television  |
| <input type="radio"/> Meetings | <input type="radio"/> Restaurant | <input type="radio"/> Travel      |
| <input type="radio"/> Music    | <input type="radio"/> Social     | <input type="radio"/> Other _____ |

Below are four listening lifestyles that range from frequent to rare background noise you might experience throughout your day. When you think about your daily activities, in addition to your less frequent but important activities, which lifestyle best describes you now and where you would like to be?

**Please select one for your current lifestyle and one for your desired lifestyle.**

**Active Lifestyle** (Frequent Background Noise)

- Current    Desired

**Casual Lifestyle** (Occasional Background Noise)

- Current    Desired

**Quiet Lifestyle** (Limited Background Noise)

- Current    Desired

**Very Quiet Lifestyle** (Rare Background Noise)

- Current    Desired

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Patient Name \_\_\_\_\_ Date \_\_\_\_\_

### General History

When was your last hearing exam? \_\_\_\_\_ By whom? \_\_\_\_\_

What were the recommendations? \_\_\_\_\_

How long ago did you start to notice a decline in your hearing? \_\_\_\_\_

- Within past 90 Days    1 - 3 years    4 - 6 years    7 - 10 years    10+ years

Have you ever used assistive listening devices?  Yes    No

Do you suffer from acute or chronic dizziness?  Yes    No

Has anyone in your family suffered hearing loss?  Yes    No   If yes, who? \_\_\_\_\_

### Medical History

- Diabetes                       Radiation therapy to local area    TMJ    Cardiovascular Disease  
 Cognitive ability               Chemotherapy within 6 months    Compromised immune system

Allergies to any medications, plastics, etc.? \_\_\_\_\_

Current medications (i.e. blood thinners) \_\_\_\_\_

Have you ever had ear surgery?  Yes    No   If yes, which ear? \_\_\_\_\_

Type? \_\_\_\_\_

Do you have regular MRIs?               Yes    No

Please list all major surgeries and illnesses (past 10 years) \_\_\_\_\_

### For Office Use Only:

### Right Ear

### Left Ear

<b>Interview</b>	Patient Experience	<input type="radio"/> Poor <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (Past 90 days) <input type="radio"/> Excessive noise exposure	<input type="radio"/> Poor <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (Past 90 days) <input type="radio"/> Excessive noise exposure
	Audiometric Range	<input type="radio"/> Within range <input type="radio"/> Out of range	<input type="radio"/> Within range <input type="radio"/> Out of range
<b>Examination</b>	Middle Ear & Outer Ear	<input type="radio"/> TM Perforation <input type="radio"/> PE tube <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Cerumen buildup <input type="radio"/> Chronic or acute drainage	<input type="radio"/> TM Perforation <input type="radio"/> PE tube <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Cerumen buildup <input type="radio"/> Chronic or acute drainage
	Skin Condition	<input type="radio"/> Contact Dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin; risk of trauma	<input type="radio"/> Contact Dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin; risk of trauma
	Ear Geometry	<input type="radio"/> Too Narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped	<input type="radio"/> Too Narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped