

Hearing Health Assessment

New



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

Interview	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
Examination	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

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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 _____ |