

Hearing Health Profile

Name _____ DOB _____ Age _____

How did you hear about us? _____

When was the last time you had your hearing tested? _____

Do you have difficulty hearing? No Yes

How long have you noticed hearing loss?

Recently (less than 90 days) Less than one year

1-3 years More than 3 years

In which of the following situations do you experience difficulty hearing or understanding?

- | | | | |
|---|--------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> One-On-One Conversations | <input type="checkbox"/> Spouse | <input type="checkbox"/> TV/Radio | <input type="checkbox"/> Small Groups |
| <input type="checkbox"/> Crowds | <input type="checkbox"/> In the Car | <input type="checkbox"/> Movies/Auditorium | |
| <input type="checkbox"/> Phone | <input type="checkbox"/> Restaurants | <input type="checkbox"/> Church/Synagogue | |

Is your hearing loss in one or both ears? Right Left Both

Do you have pain, discomfort or drainage from your ears? No Yes

Do you have any ringing, buzzing, other noises in your ears? No Yes

Do you have dizziness, loss of balance or light-headedness? No Yes

Have you ever been exposed to extremely loud noise? No Yes

Is there anyone in your family who has hearing loss? No Yes

Have you ever had surgery on your ear(s)? No _____ If yes, please explain _____

Do you take medication on a regular basis? If yes, what are these medications for?

No Yes _____

Do you have vision problems? No Yes Do you wear glasses? No Yes

Have you had surgery with general anesthesia in the past 5 years? No Yes

Have you experienced any head injury or head trauma? No Yes

Have you ever worn a hearing device? No Yes

Do you wear hearing device now? No Yes

If so, what type of hearing device do you wear? _____

If we find through our evaluation that we can help you, are you ready for that help? No Yes

Patient Signature _____ Date _____