Hearing Care Center

Name ____________________________

Referred by ________________________

Occupation ________________________

Date _____________________________

Reason for referral ________________________

1. When did you first notice the problem? ________________________

2. Do you know the reason for this problem? ________________________

3. Has it become worse? If so, explain ________________________

4. Do you hear better in one ear? If so, explain ________________________

5. Any history of hearing loss in your family? If so, explain ________________________

6. Do you wear a hearing aid? Yes or No

   If yes, how long? ________________________

   Is it satisfactory? Please explain ________________________

7. Have you ever been exposed to loud noise, recently or in the past? Yes or No (please check (v) all that apply)

   - Firearms
   - Factory work
   - Military equipment
   - Power tools
   - Music
   - Farm equipment
   - Explosions
   - Heavy equipment
   - Motorcycles/recreational vehicles
   - Other ________________________

8. Please check (v) if you have experienced any of the following:

   - Excessive ear wax
   - Ear drainage/bleeding
   - Swimmer’s Ear
   - Ear pressure/fullness
   - Popping sensation in the ear
   - Ear pain
   - Fluctuating hearing loss
   - Fluid behind the eardrum
   - Dizziness/Vertigo
   - Sensitivity to loud noises

9. Please check (v) if you have been diagnosed with any of the following:

   - Otosclerosis
   - Cholesteatoma
   - Sudden hearing loss
   - Labyrinthitis
   - Meniere’s disease
   - Barotrauma
   - Permanent hearing loss
   - Ossicular dislocation/fixation
   - Acoustic neuroma
   - Bell’s palsy

10. Please list your current prescriptions, including vitamins, supplements, herbal remedies or over the counter:

    | Medication | Reason |
    |------------|--------|
    | 1.         |        |
    | 2.         |        |
    | 3.         |        |
    | 4.         |        |
    | 5.         |        |

   *If needed, please list additional medications on a separate piece of paper.
11. Have you ever used tobacco products of any kind? Yes or No

12. How many alcoholic drinks per week do you consume?

13. Please check (v) if you have experienced any of the following

- Heart disease
- Stroke/TIA
- Diabetes
- High blood pressure
- Hypothyroidism
- Asthma
- Mental illness
- Depression or anxiety
- Migraines
- Mumps
- Meningitis
- Measles
- Scarlet fever
- HIV/AIDS
- Tuberculosis
- Visual Problems
- Hepatitis A, B or C
- Liver Problems
- Kidney or renal problems
- Chronic sinus infections
- Environmental allergies
- Cancer
- Radiation/chemotherapy
- Long term IV antibiotics
- Head trauma
- Loss of consciousness
- Exposure to chemicals/solvents

14. Please read through each listening situation and evaluate how well you hear. Also determine how important it is for you to hear in that situation.

<table>
<thead>
<tr>
<th>Hearing Quality</th>
<th>Poor</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Importance to you</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Somewhat</td>
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</tr>
<tr>
<td></td>
<td>Very</td>
<td></td>
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<tr>
<td>Quiet (one on one conversation)</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Television</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Music</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Leisure activities</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
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<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
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<td>1</td>
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<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
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<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
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<tr>
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<td>3</td>
<td>4</td>
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<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
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<tr>
<td>Male voice</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
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<tr>
<td>Child's voice</td>
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<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>1</td>
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15. What do you hope to gain from this testing?