SAN DIEGO Hearing Center

Hearing Health Assessment

TO BE COMPLETED BY PATIENT

Patient Name _____ Sex ☐ M ☐ F DOB_____ /_____ /_____
First Last MI MM DD YYYY

What would you like to accomplish at today's appointment? _____

_____

_____

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 5–10 Years ☐ 10+ Years

Have you ever utilized hearing devices? ☐ Yes ☐ No If yes, describe your satisfaction _____

_____

_____

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when: _____Which ear: _____Name of procedure: _____

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce a significant amount of wax? ☐ Yes ☐ No Have you ever had any trauma to the head? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No Do you suffer from dizziness? ☐ Yes ☐ No

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No Do you have a family history of hearing loss? ☐ Yes ☐ No

Are you currently using any medications? ☐ Yes ☐ No

If yes, please list _____

Do you have a history of any of the following? ☐ Measels ☐ Mumps ☐ Diabetes ☐ Pneumonia

☐ Frequent Headaches ☐ High Fevers ☐ Meningitis ☐ Other (describe) _____

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawnmower ☐ Other (describe) _____

Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient vision ☐ Good ☐ Fair ☐ Poor

Are there any specific features you are interested in for your hearing solution? _____

_____

_____

THIS PORTION TO BE COMPLETED BY HEARING CARE PROFESSIONAL

- ☐ Quiet Conversation
- ☐ Door Bell
- ☐ Phone Ringing
- ☐ Alarms (Clock, Security, Timers, etc.)

Total _____

- ☐ Home Telephone
- ☐ Driving
- ☐ Religious Services
- ☐ Adult Conversations
- ☐ Small Family Gatherings
- ☐ Quiet Restaurants

Total x2 _____

- ☐ Cell Phones
- ☐ Shopping
- ☐ Movie Theaters
- ☐ Health Clubs
- ☐ Small Group Meetings
- ☐ Conversations with Children
- ☐ Television
- ☐ Open/Reverberant Home
- ☐ iPod®/Personal Music Players

Total x3 _____

- ☐ Outdoor Activities
- ☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)
- ☐ Busy Restaurants
- ☐ Frequent Social Gatherings
- ☐ Smart Phones
- ☐ Conference Calls
- ☐ Multimedia Connectivity (Home Theater, Computer, Phone, etc.)
- ☐ Travel & Airports
- ☐ Concerts & Arts
- ☐ Group Presentations

Total x4 _____ Grand Total _____

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic **Does the companion agree?** ☐ Yes ☐ No

What are the top 3 environments you would like to hear better in?	**SCALE OF 1-4**	**PRE**	**POST**
1.			
2.			
3.			

NOTES: