Idaho State University
Audiology

Hearing Health Assessment

File # ____________________

TO BE COMPLETED BY PATIENT

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

How did you find out about us?

☐ Advertisement ☐ Insurance ☐ Referred by Patient ____________________

☐ Consumer Seminar/Health Fair ☐ Employer ☐ Referred by Physician ____________________

☐ Internet/Website ☐ Yellow Pages ☐ Other ____________________

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 ☐ N/A

Have you ever worn hearing devices? ☐ Yes ☐ No If yes, describe your satisfaction ____________________

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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 experience 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 experience dizziness? ☐ Yes ☐ No

Do you experience tinnitus (ringing in the ears)? ☐ Yes ☐ No

Do you have a family history of hearing loss? ☐ Yes ☐ No

Do you have a history of any of the following? ☐ Cancer ☐ Kidney ☐ Diabetes ☐ Pacemaker ☐ High Blood Pressure

☐ Frequent Headaches ☐ Other (describe) ____________________

Have you been exposed to excessive noise levels in any of the following situations?

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

Rate your dexterity ☐ Good ☐ Fair ☐ Poor Rate your vision ☐ Good ☐ Fair ☐ Poor

Are there any specific hearing aid features you are interested in? ____________________

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PLEASE CHECK ANY BOXES WHERE YOU WOULD LIKE TO HEAR BETTER:

- ☐ 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. ______________________________		_______	_______

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