Hearing Health Report

About You

Patient Name: _____ Today's Date: _____

Date of Birth: _____ ☐ Male ☐ Female

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Alternative Phone: _____

EMail: _____ Occupation: _____ ☐ Past ☐ Present

Marital Status: ☐Single ☐Married ☐Widowed / Spouse's name: _____

Name of Physician: _____ Location: _____

Permission to release test information to your physician?: ☐Yes ☐No _____
Signature

Primary Health Ins: _____ Policy (ID#): _____ Group#: _____

Secondary Health Ins: _____ Policy (ID#): _____ Group#: _____

How did you hear about us? ☐Mail ☐Phone ☐Newspaper ☐Yellow Pages
☐Website ☐Television ☐Sign ☐Other _____

If you were referred to us, who may we thank? _____

Your Hearing Health History

Allergies?: _____ Are you an insulin-dependent diabetic?: _____

Please list any medications you are currently taking: _____

_____

Do you have any ringing in your ears?: ☐Right Ear ☐Left Ear For how long?: _____

Have you previously had a hearing test?: ☐Yes ☐No If so, when?: _____

Have you received any medical or surgical treatment for a hearing loss?: _____

If Yes, when?: _____ Physician/ENT: _____

Additional information about treatment: _____

Any history of, or active drainage from, the ear within the previous 90 days?: ☐Yes ☐No

Any history of sudden or rapidly progressive hearing loss within the previous 90 days?: ☐Yes ☐No

Have you experienced any acute or chronic dizziness?: ☐Yes ☐No

Have you experienced any pain or discomfort?: ☐Right Ear ☐Left Ear

Office Use Only

Any visible congenital or traumatic deformity of the ear?: _____

Visible evidence of significant cerumen accumulation or a foreign body in the ear canal?: _____

Audiometric air-bone gap equal to, or greater than, 15 dB at 500 Hz, 1000 Hz and 2000 Hz?: ☐ Yes ☐ No

Communication Assessment

Do you have difficulty hearing and/or understanding speech?_____

If yes, do you know what caused your hearing loss?_____

_____

In which environments do you have difficulty hearing?_____

Do others perceive that you have difficulty hearing?_____ Whom?_____

How long have you noticed difficulty with your hearing?_____

Do you hear well on the telephone?_____

Do you use a special amplified telephone?_____ For which ear?_____

Who encouraged you to come in today to see our hearing professional?_____

Would you wear a hearing aid if it helped?_____ Is the size of the instrument important?_____

What has encouraged you NOW to make a positive decision about your hearing?_____

_____

_____

Amplification History *(if applicable)*

Do you currently wear hearing aids? ☐ No ☐ Left Ear ☐ Right Ear

Make: _____ Model:_____ Date Fitted:_____

Make: _____ Model:_____ Date Fitted:_____

If you could improve something about your current hearing instruments, what would it be?:_____

_____

Notice of Privacy Practices

We are committed to our patients right to privacy. All information regarding your condition, diagnosis or treatment is strictly confidential and will only be released with your written consent to your primary care physician, family, friends, employers, attorneys or insurance companies.

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I have read, understand and I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

X _____

Signature of Patient (or patient's representative) **Date**

Legal authority of representative _____

Hearing Care Professional_____ Lic. #:_____

Office Location_____

Hearing Pre-Assessment

Patient Name: _____ **Date:** _____

Telephone: _____ **Score:** _____

Please answer the following questions by checking the appropriate response:

	Yes	Sometimes	No
1. Does a hearing problem cause you to have difficulty understanding in group situations?	☐	☐	☐
2. Does a hearing problem cause you to ask people to repeat what they have said?	☐	☐	☐
3. Do you have difficulty when someone speaks in a whisper?	☐	☐	☐
4. Does a hearing problem cause you to ask people to speak louder or move closer to you?	☐	☐	☐
5. Does a hearing problem cause you difficulty when listening to tv or radio?	☐	☐	☐
6. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐	☐	☐
7. Does a hearing problem cause you avoid situations or activities more often than you would like?	☐	☐	☐
8. Does a hearing problem cause you have difficulty on the phone?	☐	☐	☐
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐	☐	☐
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐

SERVICES PERFORMED

Date		Initials