PATIENT HEARING EVALUATION

PERSONAL INFORMATION

Name ______________________________ Date of Birth ______________
(Last Name) (First Name) (Middle Initial)

Address ______________________________
(Street Number) (City) (State) (Zip)

Phone ______________ Spouse/Relative ______________

Family Physician ______________________________

E-mail Address ______________________________ Date ______________

ASSESSMENT OF COMMUNICATION PROBLEMS

Do you hear people speaking but have difficulty in understanding their words? ______________
Do you notice that people tend to mumble? ______________
Do you seem to hear some people better than others? ______________
Do you have difficulty understanding in situations with a lot of background noise? ______________
Do you have difficulty understanding in small group situations? ______________
Do you have more difficulty understanding when you cannot see the speaker's face? ______________
Do you have problems understanding a sermon in church or a lecture in a large hall? ______________
Do you like to have the television or radio turned up louder than normal? ______________
Do people ever have to raise their voice or repeat themselves? ______________
Do you have difficulty understanding on the telephone? ______________ Which ear do you use? ______________
Do you always hear the phone when it rings? ______________
Where does your hearing difficulty give you the most trouble? ______________
How often are you avoiding social situations you enjoy because of not hearing clearly? ______________
Do you feel you need to wear hearing instruments? ______________
Would you like an instrument that was easy to hide? ______________
Where would you receive the greatest benefit if we found hearing instruments to be helpful? ______________

MEDICAL HISTORY OF HEARING IMPAIRMENT

*Visible congenital or traumatic deformity of the ear .... Yes ❑ No ❑
*Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.... Yes ❑ No ❑
*Have you experienced any acute or chronic dizziness? .... Yes ❑ No ❑
*Have you experienced any pain or discomfort in your ears? .... Yes ❑ No ❑
*Any history of active drainage from the ear within the previous 90 days? .... Yes ❑ No ❑
*Any history of sudden or rapidly progessing hearing loss within the previous 90 days?...... Yes ❑ No ❑
*Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? .. Yes ❑ No ❑
If answer is "YES" to any of these questions (*) client must be referred to a physician or ear specialist prior to a hearing aid fitting.

Make ______________
Serial # ______________
Date Ordered ______________
Date Fit ______________
Date Closed ______________
Warranty Exp. ______________
Payment Method ______________

Do you have any ringing or noises in your ears? .... Yes ❑ No ❑
Have you ever seen a physician/ear specialist regarding your hearing? .... Yes ❑ No ❑
Would you like a report of our findings sent to your doctor for his records? .... Yes ❑ No ❑
When was your hearing last tested? ______________
What were the results? ______________
What do you feel caused any hearing loss you may have? ______________
Which ear do you feel you hear the best with? ______________
Is there a history of hearing loss in your family? ______________
What kind of work have you done for most of your life? ______________
What difficulties is your hearing loss causing you in your occupation? ______________