

Hearing Health History

Date: _____

Patient Information

Name: _____ DOB: _____

When was your last hearing test? _____ Never had my hearing test

Do you have hearing loss? Yes No I don't know

If yes, which ear(s)? Right Left

How did your hearing loss start? Gradual Fluctuating Sudden Longstanding

Please check all that apply:

Vertigo	Constant	Recent
	Intermittent	1 yr+
Dizziness	Infrequent	Often
Tinnitus	Right Ear	Left Ear
Describe: _____		
Ear Fullness/pressure	Right Ear	Left Ear
Ear Surgery	Right Er	Left Ear
Describe: _____		

I have difficulty understanding what people are saying in the following areas (check all that apply): Home Work Social Settings Restaurants Car Meetings

The person I have the most difficulty understanding is _____.

What is your hearing aid experience?

I have a hearing device and use it regularly on the ___ right ear ___ left ear.

I have a hearing device, but don't use it, or use it only occasionally.

I tried a hearing device, but returned it.

I have inquired about hearing devices at another office(s), but did not purchase at that time.

I have never used a hearing device.

4. On a scale of 1-10, what is your readiness to do something about your hearing loss?
not motivated 1 2 3 4 5 6 7 8 9 10 very motivated

Please check any of the following medical conditions you have experienced:

Diabetes Stroke Autoimmune Disease Chemotherapy Vision problems

Heart disease Head injury Memory loss Cardiac issues

How would you rate your skill level using a smartphone? (check boxes)

I could teach a class on how to use a smartphone.

I know a little about my smartphone, but I'd like to know more.

I only use my smartphone when I have to.

I don't have a smartphone.

What is the most important issue we address during your visit today?

Medication	Dosage	Frequency

Do you take blood thinners? Yes No

Patient signature: _____

Date: _____