HEARING HEALTH ASSESSMENT

Patient Name: _____ Date: _____

Have you ever had a hearing exam? ☐ Yes ☐ No

If yes, when and where? _____ What were the results? _____

How long ago did you notice a decline in your hearing? ☐ Within one year ☐ 1-5 years ☐ 6-10 years ☐ 10+ years

Have you ever worn/used hearing devices? ☐ Yes ☐ No If yes, describe your experience: _____

_____

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when? _____ Which ear? _____

Name of procedure: _____

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

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

Please check all that apply:

☐ Pain or discomfort in ears	☐ Pressure in ears	☐ Frequent headaches	☐ Drainage from ear
☐ Excessive earwax	☐ Dizziness	☐ High fevers	☐ Chemo/Radiation
☐ Chronic ear infections	☐ Infectious Disease	☐ Obesity	☐ Tinnitus (ringing)
☐ Wear a pacemaker	☐ Family history of hearing loss	☐ Other: _____	

Do you currently smoke? ☐ Yes ☐ No Have you smoked in the past? ☐ Yes ☐ No

Please check if you've had:

☐ Pneumonia ☐ Measles ☐ Meningitis ☐ Mumps ☐ Diabetes ☐ Trauma to head ☐ Stroke

☐ Mental Disorder (please specify): _____ ☐ Cardiovascular Disease

Any current medications? ☐ Yes ☐ No If yes, please list: _____

Please list any allergies: _____

List all chronic illnesses: _____

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

☐ Workplace ☐ Music ☐ Lawnmowers ☐ Military ☐ Motorcycles ☐ Firearms ☐ Other: _____

How would you rate your dexterity? ☐ Good ☐ Fair ☐ Poor Your vision? ☐ Good ☐ Fair ☐ Poor

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

_____

_____

_____

Audiologist's Notes: _____

_____

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