Hear in ARIZONA LLC
Life never sounded so good!

Hearing Health Assessment

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

When was your last hearing exam? _____ By whom? _____

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 ☐ Other (describe) _____

☐ Excessive earwax ☐ Dizziness ☐ High fevers _____

☐ Chronic ear infections ☐ Tinnitus (ringing in ears) ☐ Smoker _____

☐ Wear a pacemaker ☐ Family history of hearing loss ☐ Obesity

Please check if you've had:

☐ Pneumonia ☐ Measles ☐ Meningitis

☐ Mumps ☐ Diabetes ☐ Trauma to head

Are you currently using any medications? ☐ Yes ☐ No If yes, please list: _____

_____

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 ☐ Other (describe) _____

☐ Firearms _____

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

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

_____

_____

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Does your hearing loss: (please select the most appropriate response.)

Cause you to feel embarrassed when meeting new people?	☐ Yes	☐ No	☐ Sometimes
Cause you to feel frustrated when talking to members of your family?	☐ Yes	☐ No	☐ Sometimes
Impair your ability to hear when someone speaks in a whisper?	☐ Yes	☐ No	☐ Sometimes
Make you feel handicapped?	☐ Yes	☐ No	☐ Sometimes
Cause you difficulty when visiting friends, relatives or neighbors?	☐ Yes	☐ No	☐ Sometimes
Cause you to attend lectures / concerts / religious services less often than you'd like?	☐ Yes	☐ No	☐ Sometimes
Cause you to have arguments with family members?	☐ Yes	☐ No	☐ Sometimes
Impair your ability to hear the TV or radio?	☐ Yes	☐ No	☐ Sometimes
Hamper your personal and / or social life?	☐ Yes	☐ No	☐ Sometimes
Cause you difficulty when in a restaurant with relatives or friends?	☐ Yes	☐ No	☐ Sometimes

Patient Signature: _____ Date: _____