

Hearing Health Assessment

New Patients

Patient Name _____ Date _____

General History

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

What were the recommendations? _____

How long ago did you notice a decline in your hearing?

- Within past 90 days
 1–3 years
 4–6 years
 7–10 years
 10+ years

Have you ever used assistive listening devices? Yes No

Do you suffer from acute or chronic dizziness? Yes No

Has anyone in your family suffered hearing loss? Yes No If yes, who? _____

Medical History

- Diabetes Radiation therapy to local area Compromised immune system
 Cognitive ability Chemotherapy within 6 months TMJ

Allergies to any medications, plastics, etc.? _____

Current medications (i.e. blood thinners) _____

Have you ever had ear surgery? Yes No If Yes, which ear? Right Left

Type _____

Do you have regular MRIs? Yes No

Please list all major surgeries and illnesses (*past 10 years*) _____

		Right Ear	Left Ear
EXAMINATION	Patient Experience	<input type="radio"/> Poor hearing <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (past 90 days) <input type="radio"/> Excessive noise exposure	<input type="radio"/> Poor hearing <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (past 90 days) <input type="radio"/> Excessive noise exposure
	Audiometric Range	<input type="radio"/> Within range <input type="radio"/> Out of range	<input type="radio"/> Within range <input type="radio"/> Out of range
	Middle Ear & Outer Ear	<input type="radio"/> TM perforation <input type="radio"/> PE tube <input type="radio"/> Osteoma <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Exostosis <input type="radio"/> Cerumen buildup <input type="radio"/> Keratosis obturans <input type="radio"/> Chronic or acute drainage	<input type="radio"/> TM perforation <input type="radio"/> PE tube <input type="radio"/> Osteoma <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Exostosis <input type="radio"/> Cerumen buildup <input type="radio"/> Keratosis obturans <input type="radio"/> Chronic or acute drainage
	Skin Condition	<input type="radio"/> Contact dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin, risk of trauma	<input type="radio"/> Contact dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin, risk of trauma
	Ear Geometry	<input type="radio"/> Too narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped	<input type="radio"/> Too narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped

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Does a hearing problem

	Always	Sometimes	Never
Make it difficult for you to converse on the telephone?	A	S	N
Cause others to complain that you turn up the television or radio too loud?	A	S	N
Cause you difficulty following conversation in a restaurant?	A	S	N
Limit or hamper your personal or social life?	A	S	N
Cause you to have to ask people to repeat themselves?	A	S	N
Cause you to have difficulty hearing when you are in the presence of background noise?	A	S	N
Cause you to have difficulty hearing women's or children's voices?	A	S	N
Cause you to hear people speak, but fail to understand what they are saying?	A	S	N
Cause you to feel as though others mumble?	A	S	N
Cause you to feel stressed or tired when listening for long periods of time?	A	S	N

Please provide the top three listening situations where you would like to hear better

- _____
- _____
- _____

Please select your current lifestyle, and, if different, please identify your desired lifestyle

Active Lifestyle (Frequent Background Noise)

- Current Desired

Casual Lifestyle (Occasional Background Noise)

- Current Desired

Quiet Lifestyle (Limited Background Noise)

- Current Desired

Very Quiet Lifestyle (Rare Background Noise)

- Current Desired

Notes _____
