



PATIENT DEMOGRAPHIC INFORMATION

First Name: _____ MI: _____ Last Name: _____ Date: ____/____/____

Address: _____

City, State and Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Date of Birth: _____ Who is accompanying you today? (If applicable) _____

Employment Status: Full Time ☐ Part Time ☐ Student ☐ Retired ☐ If retired, what was your occupation? _____

Marital Status: Single ☐ Married ☐ Widowed ☐ Divorced ☐ Spouse/Significant Other Name: _____

Primary Physician: _____ How did you hear about our practice? _____

MEDICAL HISTORY

1. Have you ever been diagnosed with any of the following? ☐ Diabetes ☐ High Blood Pressure ☐ Cancer
☐ Head Trauma/Injury ☐ Heart/Vascular Disease ☐ Anxiety ☐ Depression ☐ Dementia/Alzheimer's
2. Have you had any significant medical or life changes recently? If yes, please describe below. ☐ Yes
☐ No _____
3. Certain types of medications have been linked with hearing loss. If you have a copy of your medication list, please provide it to our staff. Do you take any of the following types of medications? If so, please check the appropriate box. ☐ Blood Thinners ☐ Heart Medications ☐ Insulin ☐ Chemotherapeutic Agents
☐ Pain Relievers ☐ Other _____
4. During your office visits you may encounter various materials. Are you allergic to any of the following? ☐
Latex ☐ Nitrile ☐ Plastics ☐ Rubber ☐ Silicone ☐ Other _____
5. Have you ever had medical/surgical treatment for your ears? ☐ Yes ☐ No If yes, please describe the procedure? _____

HEARING HEALTH HISTORY

1. Have you experienced any ringing or sounds in your ears? ☐ Yes ☐ No Describe: _____
2. Have you been exposed to loud sounds in your ears (work or hobbies)? ☐ Yes ☐ No _____
3. Do you have a family history of Hearing Loss? ☐ Yes ☐ No
4. Are you experiencing any ear pain or fullness today? ☐ Yes ☐ No
5. Do you find some sounds to be uncomfortably loud? ☐ Yes ☐ No

Assessment of Communication Difficulties

- 1.) Are you finding yourself saying “what” or asking others to repeat frequently? ☐Yes ☐No
- 2.) Have others mentioned that you’re having difficulty hearing? ☐Yes ☐No
- 3.) Have others mentioned that the television/phone/radio is louder than it should be? ☐Yes ☐No
- 4.) How long ago did you first notice having some difficulty Hearing or Understanding? _____
- 5.) What other hearing difficulties are you experiencing? _____
- 6.) What is the most important area of your hearing and/or understanding that you wish to find improvement? _____
- 7.) Have you ever had a Complete Hearing Evaluation? ☐Yes ☐No If yes, how long ago? _____
- 8.) If hearing loss is discovered, do you have any objections to wearing hearing aids? ☐Yes ☐No

Additional notes for your hearing care provider: _____

Hearing Inventory Screening Questionnaire for adults

The purpose of this scale is to identify the problems your hearing loss may be causing you. Circle ‘Yes’, ‘Sometimes’, or ‘No’ for each question. Do not skip any questions. If you use a hearing aid, please answer the way you hear without a hearing aid.

QUESTIONS	NO	SOMETIMES	YES
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	☐ 0	☐ 2	☐ 4
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	☐ 0	☐ 2	☐ 4
3. Do you have difficulty hearing/understanding co-workers, clients/ customers or waitstaff?	☐ 0	☐ 2	☐ 4
4. Do you feel significantly disadvantaged by a hearing problem?	☐ 0	☐ 2	☐ 4
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	☐ 0	☐ 2	☐ 4
6. Does a hearing problem cause you difficulties hearing in the movies or in the theatre?	☐ 0	☐ 2	☐ 4
7. Does a hearing problem cause you to have arguments with family members?	☐ 0	☐ 2	☐ 4
8. Does a hearing problem cause you difficulty when listening to TV or radio?	☐ 0	☐ 2	☐ 4
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	☐ 0	☐ 2	☐ 4
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐ 0	☐ 2	☐ 4
TOTALS:			
		GRAND TOTAL:	0

Newman, C. W., Weinstein, B. E., Jacobson, G. P., & Hug, G. A. (1990). The Hearing Handicap Inventory for Adults: psychometric adequacy and audiometric correlates. Ear and Hearing, 11, 430-433.

The remainder of this page is to be completed by your Hearing Care Provider

Video Otoscopic Inspection: Clear ____ Partial ____ Fully impacted ____ T.M. Observations _____

Tympanometry: Left ____ Right ____ **Pinna Length:** 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ **Canal Size:** S ☐ M ☐ L ☐ XL ☐

- ☐ **Yes** ☐ **No** Acute or chronic dizziness within the previous 90 days
- ☐ **Yes** ☐ **No** Pain or discomfort in the ear within the previous 90 days
- ☐ **Yes** ☐ **No** History of sudden or rapidly progressive hearing loss within the previous 90 days
- ☐ **Yes** ☐ **No** Unilateral hearing loss of sudden or recent onset within the previous 90 days
- ☐ **Yes** ☐ **No** History of active drainage from the ear within the previous 90 days
- ☐ **Yes** ☐ **No** 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** Audiometric air-bone gaps equal to or greater than 15 dB at 500, 1K, and 2K Hz

Speech Testing: Live or Rec. **WRS:** Left: ____% @ ____ dB Right: ____% @ ____ dB Bilateral: ____% @ ____ dB
English / Spanish **SRT:** Left: ____ dB Right: ____ dB **QUICKSIN:** _____

Comments: _____

Product demonstration details:

Product Recommendations/Price:

1.) _____ 2.) _____ 3.) _____