



Hearing Health Assessment - New Patients

Patient Name _____ Date _____

Medical Record Number _____ Date of Birth _____

Medical History

Have you ever had any of the following:

Diabetes	☐ Yes	☐ No
Radiation therapy to local area	☐ Yes	☐ No
Chemotherapy w/in past six months	☐ Yes	☐ No
Compromised immune system	☐ Yes	☐ No
TMJ	☐ Yes	☐ No

General History

Last hearing exam? _____ By whom? _____

Any family history of hearing loss that occurred in childhood for that person?	☐ Yes	☐ No
Any medically relevant history with the ears (e.g., infections, surgery, etc.)?	☐ Yes (R/L)	☐ No
Any history of consistent noise exposure, either currently or in the past?	☐ Yes	☐ No
Any constant ringing, roaring, buzzing noises in the ear/head?	☐ Yes (R/L)	☐ No
Any current pain, discomfort or pressure in either ear?	☐ Yes (R/L)	☐ No
Any dizziness or vertigo?	☐ Yes	☐ No

How would you rate your overall hearing on a scale of 1 to 10 (10 is the best)

1 2 3 4 5 6 7 8 9 10

Have you had any experience with amplification? ☐ Yes (R/L) ☐ No

Rate the following situations, based on your hearing, on a scale of 1 to 10 (10 is the best)

Conversing on the telephone:

1 2 3 4 5 6 7 8 9 10

Conversation in a quiet room with one or two people:

1 2 3 4 5 6 7 8 9 10

Television:

1 2 3 4 5 6 7 8 9 10

Music:

1 2 3 4 5 6 7 8 9 10

Restaurants:

1 2 3 4 5 6 7 8 9 10

Church:

1 2 3 4 5 6 7 8 9 10

Car:

1 2 3 4 5 6 7 8 9 10

Large groups:

1 2 3 4 5 6 7 8 9 10

Other:

1 2 3 4 5 6 7 8 9 10

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

- 1.
- 2.
- 3.

How motivated are you to accept a solution to your hearing loss, on a scale of 1 to 10 (10 is the most)?

1 2 3 4 5 6 7 8 9 10