Hearing HealthCare Centers

General Information Date: _____

Full Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____ ☐ Male ☐ Female

Marital Status ☐ Single ☐ Widowed ☐ Married Name of Companion: _____

Employment Status: ☐ Retired ☐ Full Time ☐ Part Time Occupation: _____

Snowbird Address: Address: _____ City: _____ State: _____ Zip Code: _____

How did you hear about us? _____

What motivated you to come in today? _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Insurance Information ****** Please allow us to copy your insurance cards ******

If you are not the primary insured please complete:

Name: _____ Date of Birth_____ Relationship: _____

Medical History

Primary Physician: _____ Phone: _____

May we send a copy of test results to your physician? (Medicare physicians automatically receive a report)

☐ Yes ☐ No

Please circle any of the following conditions that apply (including past and present conditions):

Diabetes	Self	Family	None	Heart Problems	Self	Family	None
Hypertension	Self	Family	None	Cancer	Self	Family	None
Thyroid problems	Self	Family	None	Hearing Loss	Self	Family	None

If you circled "Self", please explain: _____

Please provide a list of medications for us to copy for your file, or list current medications, dosages and frequency, along with over the counter medications and vitamin supplements below:

_____

_____

_____

1. In general, would you say your health is: *(circle number)*

Excellent	Very Good	Good	Fair	Poor
1	2	3	4	5

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For each question, please give the answer that describes the way you have been feeling during the past 4 weeks.

		Extreme	Quite a bit	Moderate	A little bit	None at all
2.	How much difficulty did you have doing your work or other regular daily activities as a result of your physical health?	1	2	3	4	5
3.	To what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems?	1	2	3	4	5
4.	To what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?	1	2	3	4	5

About your Ears

Deformity of the ear? ___ Yes ___ No
Do you have sudden pain in your ears? ___ Yes ___ No
Sudden or long-term dizziness? ___ Yes ___ No
Sudden/rapid hearing loss in the past 90 days? ___ Yes ___ No
Hearing loss in one ear that occurred in the past 90 days? ___ Yes ___ No
Have you ever had wax removed from your ears? ___ Yes ___ No
Drainage from either ear in the past 90 days? ___ Yes ___ No
Have you ever had ear surgery? ___ Yes ___ No Date:_____
Which do you believe is your poorer ear? ___ Left ___ Right ___Not Sure/Same
Have you ever seen an ear doctor? Name:_____

Diseases of the ear Have you ever been diagnosed with the following conditions?

Meniere's	___Yes	___No	___Not Sure
Cholesteatoma	___Yes	___No	___Not Sure
Mastoiditis	___Yes	___No	___Not Sure
Labyrinthitis	___Yes	___No	___Not Sure
Otitis Media/Chronic ear infections	___Yes	___No	___Not Sure

About Your Hearing

Do your friends or family complain that you do not hear well? ___ Yes ___No

What do they notice or how would they describe your hearing? _____

_____

When was your last hearing test? _____

Do you have ringing in your ears? ___ Yes ___ No Which ear? ___ Right ___Left ___Both

Please describe the sound_____

Have you been exposed to excessive noise? ___ Yes ___ No Veteran/Military? ___Yes ___ No

Please describe_____

Have you ever worn a hearing instrument? ___ Yes ___ No Date fit? _____

What brand/type? _____ Results? _____

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Please rank the following items on a scale of 1 to 4 in terms of importance when purchasing a hearing device. (1= Most important, 2= Important, 3= Somewhat important, 4= Least Important)

____Sound Quality & Clarity ____ Durability/Reliability _____ Size & Appearance _____ Cost

On a scale of 1-10 where do you feel that you are (psychologically) in terms of wanting to do something about your hearing loss? (Please Circle One)

Not Motivated 1 2 3 4 5 6 7 8 9 10 Very Motivated

Perception of Hearing Questionnaire

Please circle the answer that best describes how often these statements apply to you:

Does a hearing problem cause you to feel embarrassed when you meet new people?	YES	SOMETIMES	NO
Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES	SOMETIMES	NO
Do you have difficulty hearing when someone speaks in a whisper?	YES	SOMETIMES	NO
Do you feel handicapped by a hearing problem?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES	SOMETIMES	NO
Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when listening to TV or radio?	YES	SOMETIMES	NO
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO
Does a hearing problem cause you to feel like hearing and listening cause you extra effort?	YES	SOMETIMES	NO
Are you aware of using visual cues or compensation (ie. Lip-reading) to help you hear better?	YES	SOMETIMES	NO

What situations do you believe are most impacted by your hearing loss?

_____

_____

Signature: _____ Date: _____

By signing this document you are affirming that all the information you have provided is accurate to the best of your knowledge.