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

How do you prefer your appointments to be confirmed? ☐ Phone ☐ Email ☐ Text

What type of cell phone do you use (if applicable)? _____

Marital Status: *circle one*: Single Widowed Married Name of Companion: _____

Employment Status: Retired Full-Time Part-Time Unemployed 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 person insured, please complete:

Name: _____ Date of Birth_____ Relationship: _____

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:

_____

_____

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
Neuropathy	Self	Family	None	If self, how was it treated? _____			
Thyroid Problems	Self	Family	None	Hearing Loss	Self	Family	None
Parkinson's Disease	Self	Family	None	Auto Immune Disorder	Self	Family	None
Sleep Apnea	Self	Family	None	Arthritis	Self	Family	None
Dementia/Alzheimers	Self	Family	None				

If you circled "Self", please explain:

_____

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Please *answer the following by circling "yes" or "no" and explain any "yes" answers below:*

Have you had any recent falls?	Yes	No
Any concerns with cognition or memory problems?	Yes	No
Chronic ear infections or ear diseases?	Yes	No
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:_____	

If you circled "yes" to any of the above, please explain all:

_____

_____

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? _____

Signature: _____ Date: _____

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

If hearing is the primary reason for your visit today, please continue to the next page for "Perception of Hearing" Questionnaire.

Perception of Hearing Questionnaire

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

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Does your hearing problem or current hearing aids cause you to feel embarrassed when you meet new people?	YES	SOMETIMES	NO
Does your hearing problem or current hearing aids 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 your hearing problem or current hearing aids cause you difficulty when visiting friends, relatives, or neighbors?	YES	SOMETIMES	NO
Does your hearing problem or current hearing aids cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
Does your hearing problem or current hearing aids cause you to have arguments with family members?	YES	SOMETIMES	NO
Does your hearing problem or current hearing aids 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 your hearing problem or current hearing aids cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO
Does your hearing problem or current hearing aids 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

Please rank the following items on a scale of 1 to 4 in terms of importance if hearing treatment is recommended. (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

What 2-3 areas of your life have been affected by your hearing difficulties?

_____

_____