AUDIOLOGY ASSOCIATES OF HOLLADAY

Hearing Health Assessment

Patient Name ______________________________ Sex ☐ M ☐ F Date ____/____/____
First MI Last MM DD YYYY

TO BE COMPLETED BY PATIENT

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

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 6–10 Years ☐ 10+ Years

Have you ever utilized hearing devices? ☐ Yes ☐ No If yes, describe your satisfaction ____________

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when: ________ Which ear: ________ Name of procedure: ________

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce a significant amount of wax? ☐ Yes ☐ No Have you ever had any trauma to the head? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No Do you have a family history of hearing loss? ☐ Yes ☐ No

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No

Are you currently using any medications? ☐ Yes ☐ No If yes, please list ____________

Do you have a history of any of the following? ☐ Measles ☐ Mumps ☐ Diabetes ☐ Pneumonia

☐ Frequent Headaches ☐ High Fevers ☐ Meningitis ☐ Other (describe) ____________

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawn Mower ☐ Other (describe) ____________

Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient vision ☐ Good ☐ Fair ☐ Poor

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic Does your companion agree? ☐ Yes ☐ No

What are the top three environments in which you would like to hear better? SCALE OF 1-4 PRE POST

1. ______________________________ ________ ________

2. ______________________________ ________ ________

3. ______________________________ ________ ________

Are there any specific features you are interested in for your hearing devices? ____________

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