

# Hearing Health Assessment

## New Patients

a member of AUDIGY GROUP<sup>®</sup>

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### Medical History

Reason for today's appointment: \_\_\_\_\_

Allergies to any medications, plastics etc.? \_\_\_\_\_

Current medications: \_\_\_\_\_

Have you ever had ear surgery? ☐ Yes ☐ No If Yes, which ear? ☐ Right ☐ Left

Type: \_\_\_\_\_

Please list all major surgeries: \_\_\_\_\_  
(Past 10 years)

Please list any serious illnesses: \_\_\_\_\_  
(Past 10 Years)

Are you diabetic? ☐ Yes ☐ No

### General History

When was your last hearing exam? \_\_\_\_\_ By whom? \_\_\_\_\_

What were the recommendations? \_\_\_\_\_

How long ago did you notice a decline in your hearing?

☐ Recently ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ More than 10 years

Have you ever used assistive listening devices? ☐ Yes ☐ No

In which ear is your hearing poorest? ☐ Right ☐ Left ☐ Same

Which ear do you use on the telephone? ☐ Right ☐ Left ☐ Either

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

Have you experienced any drainage from your ear(s) within the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Do you suffer from pain or discomfort in your ear(s)? ☐ R ☐ L ☐ Both ☐ Neither

Do you suffer from acute or chronic dizziness? ☐ Yes ☐ No

Is there a visible congenital or traumatic deformity of the ear? ☐ Yes ☐ No

Describe: \_\_\_\_\_

Is there a visible evidence of significant cerumen accumulation or a foreign body in the ear canal?

☐ R ☐ L ☐ Both ☐ Neither

Describe: \_\_\_\_\_

Is the audiometric air-bone gap equal to or greater than 15 dB at 500 Hz, 1K Hz, and 2K Hz.

☐ R ☐ L ☐ Both ☐ Neither

Describe: \_\_\_\_\_

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### Does a hearing problem...

	Always	Sometimes	Never
Cause you to feel embarrassed or uncomfortable when meeting new people?	1	2	3
Cause you to feel frustrated when talking to members of your family?	1	2	3
Make it difficult for you to converse on the telephone?	1	2	3
Cause you difficulty following conversations in a restaurant?	1	2	3
Cause you to have to ask people to repeat themselves?	1	2	3
Cause you to have difficulty hearing in the presence of background noise?	1	2	3
Cause you to have difficulty hearing women's or children's voices?	1	2	3
Cause you to feel as though others mumble?	1	2	3
Cause you to attend religious or social functions less than you would like?	1	2	3
Cause you to have arguments with family or friends?	1	2	3
Cause you to feel stressed or tired when listening for long periods of time?	1	2	3
Cause others to complain that you turn up the television or radio too loud?	1	2	3
Limit or hamper your personal or social life?	1	2	3
Cause you to hear people speak but fail to understand what they are saying?	1	2	3

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### Please select your current lifestyle and if different please identify your desired lifestyle.

#### Active Lifestyle (Frequent Background Noise)

☐ Current ☐ Desired

#### Casual Lifestyle (Occasional Background Noise)

☐ Current ☐ Desired

#### Quiet Lifestyle (Limited Background Noise)

☐ Current ☐ Desired

#### Very Quiet Lifestyle (Rare Background Noise)

☐ Current ☐ Desired

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_