HEARING HEALTH REPORT

NAME:

OUR INQUIRY, OBSERVATION AND HEARING TEST RESULTS FOR:

Patient's Name ______________________ Today's Date __________

Gender ☐ Male ☐ Female Date of Birth __________ Social Security Number __________

Address ______________________

City __________ State __________ Zip __________

Phone __________ E-mail __________

Occupation __________ ☐ Past ☐ Present

Insurance Carrier __________ I.D. No./Policy No. __________

Marital Status ☐ Single ☐ Married ☐ Widowed Name of Spouse __________

Name of Observing Party __________ Relationship __________

Name of Family Physician __________

Permission to release a copy of test information to physician? ☐ Yes ☐ No

How did you hear about us? ☐ Mail ☐ Phone ☐ Newspaper ☐ Yellow Pages ☐ Television ☐ Web ☐ Physician ☐ Referral __________

Hearing Health History

Do you have any allergies? ☐ Yes ☐ No If yes, please list __________

Are you an insulin-dependent diabetic? ☐ Yes ☐ No

Are you currently taking medication? ☐ Yes ☐ No If yes, please list __________

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Do you have arthritis? ☐ Yes ☐ No

Do you have any ringing in your ear(s)? ☐ Yes ☐ No If yes, which ear? __________

Have you previously had a hearing test? ☐ Yes ☐ No If yes, by whom? __________ Date __________

Have you received any medical or surgical treatment for a hearing loss? ☐ Yes ☐ No

If yes, when? __________ Physician/ENT: __________ Phone __________

Address __________ City __________ State __________ Zip __________

Additional information about treatment: __________

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Amplification History

Are you a current hearing aid wearer? ☐ Yes ☐ No Type __________ Ear fitted: ☐ Both ☐ Left ☐ Right

If yes, and you could improve something about your current hearing instruments, what would that be? __________

____

Do you know anyone who wears hearing aids? ☐ Yes ☐ No If yes, who? __________

Hearing Care Professional __________ License No. __________

FDA Questions

- Visible congenital or traumatic deformity of the ear? ☐ Yes ☐ No
- Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ☐ Yes ☐ No
- Any history of, or active drainage from, the ear within the previous 90 days? ☐ Yes ☐ No
- Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ☐ Yes ☐ No
- Have you experienced any acute or chronic dizziness? ☐ Yes ☐ No
- Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? ☐ Yes ☐ No
- Have you experienced any pain or discomfort? ☐ Yes ☐ No
- Audiometric air-bone gap equal to, or greater than, 15 dB at 500 Hz, 1000 Hz and 2000 Hz? ☐ Yes ☐ No

If the answer is "Yes" to any of these questions, patient must be referred to a physician or ear specialist prior to a hearing instrument fitting.

Communication Assessment

Who encouraged you to come in today to see a hearing professional? ____________________

What have others said or noticed about your hearing/understanding or communication ability? ____________________

What have you noticed about your hearing/understanding or communication ability? ____________________

How long have you noticed any difficulty? ____________________

What concerns you most about your hearing/understanding and communication difficulties? ____________________

What is it about **NOW** that made you decide to come here today? ____________________

What are some other environments or situations where hearing and communication are difficult for you? ____________________

List the environments/listening situations where communication is difficult for you in order of importance.

☐ ____________________

☐ ____________________

☐ ____________________

☐ ____________________

☐ ____________________

If I can help you hear and communicate more effectively in the places or situations you've described, is that the **RESULT** you are looking for?

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