Hearing Health Assessment

TO BE COMPLETED BY PATIENT

Patient Name _____ DOB _____/_____/_____
First Last MI MM DD YYYY

Have you ever utilized a hearing solution? ☐ Yes ☐ No If yes, describe your satisfaction _____

_____

_____

_____

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

Do your ears produce a significant amount of wax? ☐ Yes ☐ No Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No

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

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

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawnmower ☐ Other _____

Do you have a history of Chemotherapy or Radiation? ☐ Yes ☐ No Do you have a pacemaker or other implantable device? ☐ Yes ☐ No

Are there any specific features you are interested in for your hearing solution? _____

_____

_____

_____

What are the top 3 environments you would like to hear better in?

1. _____
2. _____
3. _____

NOTES:

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