

PATIENT INFO & HEARING HISTORY

PATIENT CONTACT INFO

Name: _____ Birth Date: ____/____/____

Gender: M F Married: YES NO Spouse Name: _____

Address: _____ City: _____ State: _____, Zip: _____

Phone #: Home: (____) _____ - _____ Mobile: (____) _____ - _____

E-Mail: _____@_____ How did you hear about us? _____

MEDICAL HISTORY

- Your Primary Physician: _____ Clinic _____
- Have you ever had ear surgery? NO YES, describe: _____
- Are you allergic to any medications, plastics, etc? ... NO YES, describe: _____
- Do you take blood thinner (Coumadin, Aspirin, etc.)? NO YES
- Have you been examined by your doctor in the past 6 months? NO YES

1. Are you experiencing pain or discomfort in your ear(s)? NO YES
2. Have you experienced acute or chronic dizziness? NO YES
3. Was your hearing loss sudden or rapidly progressive within the last 90 days? NO YES
4. Have you experienced any drainage from your ear(s) within the last 90 days? NO YES
5. Is there visible congenital or traumatic deformity of the ear? NO YES
6. Does any one of your biological parents or siblings have hearing loss? NO YES

Who has hearing loss Father, Mother, Brother(s), Sister(s), Grand Parent(s)

HEARING HISTORY

1. When did you first notice your hearing issue? _____. Which ear is worse? Left Right Same
2. When was your last hearing test? _____ where? _____ Never Tested
3. The cause of your hearing loss? _____ Don't know
4. Do you have a history of either constant loud noise exposure (job or armed service) or sudden impact (explosion or accident or shoot fire arms)? NO YES
5. Do you have trouble hearing on the telephone? NO YES
6. Do others mention you play the radio or TV too loud? NO YES
7. **Do you hear conversations but cannot understand words?** NO YES
8. **Do you find it difficult to understand conversations in noise?** NO YES
9. Do you experience constant annoying ringing or noises in your ears?..... NO YES
10. Are you currently wearing hearing aid(s)..... No Yes: Left Right Both

Make & Model: _____ Battery: 10A 312 13 675 Rechargeable

Style: CIC ITC ITE RIC BTE CROS. S/N: L: _____ R: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT & APPOINTMENT CANCELLATION POLICY

All information is protected and kept confidential subject to HIPAA 2003 regulations. No information will be shared or distributed to any outside source without written consent of the patient. I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

I accept Hearing of America's cancellation policy and will attend my appointment(s) punctually. In the event that I have to miss an appointment, I will notify the office at least 24 hours prior to my scheduled appointment time to reschedule or cancel. I understand there will be a \$50 charge for any no-show or non-cancelled appointments that I do not attend.

Signature: _____ Self POA Date ____/____/20____

HEARING CARE NEEDS ASSESSMENT

Name: _____ Today's Date: _____
First M.I. Last Month / Day / Year

Reason for today's appointment: _____

HEARING NEEDS ASSESSMENT

Please check the response that best describes your listening and lifestyle needs on a scale of 3 (with 1=Rarely, 2=Occasionally, 3=Often):

- | | Rarely | Occasionally | Often |
|--|----------------------------|----------------------------|----------------------------|
| 1. Are you actively working and need to communicate with people throughout the day?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 2. Do you spend time at loud activities like sporting events or concerts or live theater where you need to hear in the presence of a great deal of background noise? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 3. Do you attend large parties or go to busy restaurants?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 4. Are you involved in religious gatherings where you need to be able to hear?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 5. Do you attend work or social meetings where you need to be able to communicate?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 6. Do you go shopping or spend time in public places where being able to communicate is important?..... | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 7. Do you need to be able to communicate in quiet restaurants? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 8. Do you need to be able to communicate in small group settings? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 9. Do you need to be able to hear in one-on-one settings? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |
| 10. Do you spend quite a bit of time involved in quiet home activities? | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 |

TOTAL SCORE:

+	+
=	

LIFESTYLE CONSIDERATIONS:

What factors are important to you?

- Function of the hearing aid
- Ease of use/automatic
- Handling/dexterity
- Cosmetics
- Price

LISTENING ENVIRONMENT RATING:

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

1. _____
2. _____
3. _____