HEARING of AMERICA
To Hear. To Enjoy

*We proudly provide personalized, top quality, and compassionate hearing care services.*

1075 Hadley Ave. N., Suite 107, Oakdale, MN 55128; Phone: (651) 528-7868

Service@HearingOfAmerica.com, www.HearingOfAmerica.com

ACCREDITED BUSINESS BBB

# PATIENT INFO & HEARING HISTORY

## PATIENT INFO

Check in date: / / 20 .

Patient 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
- Are you Veteran?…… ☐ 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 anyone 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 confidential in accordance with HIPAA 2003 regulations. Patient information will not 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) at the designated time. If unable to comply with my appointment date or time, I will notify the office at least 24 hours prior to my scheduled appointment to reschedule or cancel. I understand I will be charged a $50 no-show fee for any no-show or non-cancelled appointments that occur. After three no-show or non-cancelled appointments, Hearing of America reserves the right to terminate services with the patient.

Signature: _____ ☐ Self ☐ POA Date _____/_____/_____

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# HEARING CARE NEEDS ASSESSMENT

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

## HEARING NEEDS ASSESMENT

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 working and/or do you need to communicate with people throughout the day?..... | ☐ 1 | ☐ 2 | ☐ 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? ..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 3. Do you attend large parties or go to busy restaurants?..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 4. Are you involved in religious gatherings where you need to be able to hear?..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 5. Do you attend work or social meetings where you need to able to communicate?..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 6. Do you go shopping or spend time in public places where being able to communicate is important?..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 7. Do you need to be able to communicate in noisy restaurants? ..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 8. Do you need to be able to communicate in small group settings? ..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 9. Do you need to be able to hear in one-on-one settings? ..... | ☐ 1 | ☐ 2 | ☐ 3 |
| 10. Do you spend quite a bit of time involved in quiet home activities? ..... | ☐ 1 | ☐ 2 | ☐ 3 |

TOTAL SCORE: _____ = _____ + _____ + _____

On a scale of 10, how much are you motivated to treat your hearing loss today? (1 – Not all, 10 – Absolutely)

1 2 3 4 5 6 7 8 9 10

## 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. _____

**Please provide your medical insurance card to our Patient Care Coordinator if you would like us to verify your insurance coverage and benefits for hearing aids. Thank you.**