

# Hearing Health Assessment

## Current Hearing Technology Users

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

### General History

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

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

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

- Within past 90 days   
  1–3 years   
  4–6 years   
  7–10 years   
  10+ years

Do you experience acute or chronic dizziness?     Yes     No

Does your family have a history of hearing loss?     Yes     No    If yes, who? \_\_\_\_\_

### Medical History

- Diabetes                       Radiation therapy to local area                       Compromised immune system  
 Cognitive impairment     Chemotherapy within 6 months                       TMJ

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

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

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

Type \_\_\_\_\_

Do you have regular MRIs?             Yes     No

Please list all major surgeries and illnesses (past 10 years) \_\_\_\_\_

		Right Ear	Left Ear
INTERVIEW	Patient Experience	<input type="radio"/> Poor hearing <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (past 90 days) <input type="radio"/> Excessive noise exposure	<input type="radio"/> Poor hearing <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (past 90 days) <input type="radio"/> Excessive noise exposure
	Audiometric Range	<input type="radio"/> Within range <input type="radio"/> Out of range	<input type="radio"/> Within range <input type="radio"/> Out of range
EXAMINATION	Middle Ear & Outer Ear	<input type="radio"/> TM perforation <input type="radio"/> PE tube <input type="radio"/> Osteoma <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Exostosis <input type="radio"/> Cerumen buildup <input type="radio"/> Keratosis obturans <input type="radio"/> Chronic or acute drainage	<input type="radio"/> TM perforation <input type="radio"/> PE tube <input type="radio"/> Osteoma <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Exostosis <input type="radio"/> Cerumen buildup <input type="radio"/> Keratosis obturans <input type="radio"/> Chronic or acute drainage
	Skin Condition	<input type="radio"/> Contact dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin; risk of trauma	<input type="radio"/> Contact dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin; risk of trauma
	Ear Geometry	<input type="radio"/> Too narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped	<input type="radio"/> Too narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped

# Hearing Health Assessment

## Current Hearing Technology Users

### Current hearing technology

Brand and model of your hearing technology \_\_\_\_\_

Style of technology  Behind-the-Ear  In-the-Ear (describe) \_\_\_\_\_

Do you wear technology in both ears?  Yes  No

How many years ago did you purchase your technology?  1-3  3-5  5+

### My current hearing technology...

	Yes	No
Feels comfortable	<input type="checkbox"/>	<input type="checkbox"/>
Emits feedback or whistling noises	<input type="checkbox"/>	<input type="checkbox"/>
Provides hearing confidence on a day-to-day basis	<input type="checkbox"/>	<input type="checkbox"/>
Is cosmetically appealing	<input type="checkbox"/>	<input type="checkbox"/>

### How often is your hearing technology's performance meeting your listening lifestyle needs?

	Frequently	Sometimes	Rarely		Frequently	Sometimes	Rarely
On the phone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In conversations with women or children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
While watching TV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In understanding what others are saying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In a restaurant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In reducing the feeling that people are mumbling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In social or personal life	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	In reducing the feeling of being stressed or tired after listening for long periods of time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In conversations with spouse or family	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
In background noise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

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

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

### 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 \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_