

Hearing Health Assessment

Current Hearing Technology Users

a member of AUDIGY GROUP^{US}

Patient Name _____ Date _____

General History

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

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

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

Have you ever used assistive listening devices? Yes No

Do you suffer from acute or chronic dizziness? Yes No

Has anyone in your family suffered hearing loss? Yes No If yes, whom? _____

Medical History

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

Allergies to any medications, plastics etc? _____

Current medications (i.e. blood thinners) _____

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

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Current Hearing Technology

Brand and model of your hearing technology _____

Style of technology Behind the Ear In the Ear, describe _____

Do you use technology in both ears? Yes No

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

My current hearing technology

	Always	Sometimes	Never
Feels comfortable	1	2	3
Does not emit feedback or whistling noises	1	2	3
Provides hearing confidence on a day-to-day basis	1	2	3
Is cosmetically appealing	1	2	3

My current hearing technology performance is satisfactory

	Always	Sometimes	Never		Always	Sometimes	Never
While in background noise	1	2	3	While listening to music	1	2	3
At religious services	1	2	3	While watching TV	1	2	3
At the movies	1	2	3	In group conversations	1	2	3
In the car	1	2	3	In conversations with spouse	1	2	3
On the phone	1	2	3	In conversations with children	1	2	3
In a conference room	1	2	3				
In a restaurant	1	2	3				

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 _____

