

# Hearing Health Assessment

## New Patients

a member of AUDIGY GROUP<sup>SM</sup>

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
<b>Patient Experience</b>	<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
<b>Audiometric Range</b>	<input type="checkbox"/> Within range <input type="checkbox"/> Out of range	<input type="checkbox"/> Within range <input type="checkbox"/> Out of range
<b>Middle Ear &amp; Outer Ear</b>	<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
<b>Skin Condition</b>	<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
<b>Ear Geometry</b>	<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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## Does a hearing problem

	Always	Sometimes	Never
Cause you to feel embarrassed or uncomfortable when meeting new people?	1	2	3
Cause you to feel frustrated when talking to members of your family?	1	2	3
Make it difficult for you to converse on the telephone?	1	2	3
Cause you difficulty following conversations in a restaurant?	1	2	3
Cause you to have to ask people to repeat themselves?	1	2	3
Cause you to have difficulty hearing in the presence of background noise?	1	2	3
Cause you to have difficulty hearing women's or children's voices?	1	2	3
Cause you to feel as though others mumble?	1	2	3
Cause you to attend religious or social functions less than you would like?	1	2	3
Cause you to have arguments with family or friends?	1	2	3
Cause you to feel stressed or tired when listening for long periods of time?	1	2	3
Cause others to complain that you turn up the television or radio too loud?	1	2	3
Limit or hamper your personal or social life?	1	2	3
Cause you to hear people speak but fail to understand what they are saying?	1	2	3

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

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

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