HEARING HEALTH ASSESSMENT

Patient Name _____ Date _____

Address _____ Phone Number _____

Email _____ Permission to Contact: ☐ Yes ☐ No

What are the top three environments in which you would like to hear better?

1. _____
2. _____
3. _____

Do you currently wear hearing devices or have you ever in the past? ☐ Yes ☐ No

If yes, how long? _____

Please describe satisfaction: _____

Are you currently employed? ☐ Retired ☐ Part-Time ☐ Full-Time Employer _____

Do you use a cell phone? ☐ Yes ☐ No

If no, do you prefer a landline? ☐ Yes ☐ No

If yes, what kind of cell phone do you have? ☐ Flip-Phone ☐ Apple ☐ Android

How often do you use your cell phone? ☐ Frequently ☐ Sometimes ☐ Never

Please indicate which of the following are most important to you in a hearing instrument:

☐ Aesthetics	☐ Sound Quality	☐ Bluetooth Capabilities	☐ Rechargeability
☐ Price	☐ Warranty	☐ Financing/Leasing-to-Own	☐ Service
☐ Ease of Use	☐ Maintenance	☐ Other _____	

What kinds of activities do you participate in? *Please check all that apply.*

☐ One-on-one conversation	☐ Dining out/restaurants	☐ Sporting events
☐ At-home activities	☐ Weekly religious services	☐ Theatre performances/concerts
☐ Watching television	☐ Meetings/conference calls	☐ Large gatherings/parties
☐ Car rides	☐ Outdoor activities/gardening	☐ Other _____

Do you have ringing or other noises in your ear(s)? ☐ Yes ☐ No

If yes, which ear? ☐ Right ☐ Left ☐ Both

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawn Mower ☐ Other (describe) _____

Patient Dexterity: ☐ Good ☐ Fair ☐ Poor

Patient Vision: ☐ Good ☐ Fair ☐ Poor

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