



Date _____

Name: _____ Age: _____

What Medications are you currently taking?

Do you currently use tobacco products? Yes No

HEARING HISTORY

- How long have you had trouble hearing? _____
- Was your hearing loss? Sudden Progressive Gradual Fluctuating
- Is your hearing poorer in one ear? Yes No If yes, which ear is the poorer ear? Right Left

What are 3 situations you struggle to hear in? 3 situations you notice your hearing loss the most?

1. _____
2. _____
3. _____

• **Do you have a history of:**

- Ear Infections Ear Drainage Pain in the ears Ear Surgery
 - Noise Exposure Dizziness Family History of Hearing Loss
 - Noises in Ears (Tinnitus) If yes, what does it sound like? _____
- If yes, which ear? RIGHT LEFT
Is it: CONSTANT or COMES AND GOES

HEARING AID HISTORY

Have you ever worn a hearing aid? YES NO If yes, how many years? _____

Are you currently wearing hearing aids? Right ear Left ear Both ears Do not wear hearing aids

If hearing aids are recommend, are you interested in learning more about them? Yes • No
If yes please fill out page 2.



Date _____

Hearing Aids

How often are you in each type of situation? Please respond by checking the appropriate box.

	Frequently	Occasionally	Never
1. How often do you attend theater, concerts or movies?			
2. How often do you attend lectures, religious services or meetings?			
3. How often do you go to restaurants?			
4. How often do you use the telephone / cell phone?			
5. How often do you watch television?			
6. How often do you attend small group activities? (bridge, bible study, meetings, clubs...)			
7. How often do you attend large group activities? (parties, family celebrations...)			
8. How often do you participate in outdoor activities?			
9. How often are you in reverberant places? (gyms, arenas, cafeterias...)			
10. How often do you listen to music? (live or recorded)			

Please rank the level of importance to you for each of the items below

	Not that Important	Somewhat Important	Very Important
Cosmetics/Visibility	_____	_____	_____
Ease of use/simplicity	_____	_____	_____
Rechargability	_____	_____	_____
Smart Phone Streaming	_____	_____	_____
Lowest Cost	_____	_____	_____

Hearing device success also depends on service. We have varying service plans. Please tell us if you feel that full-service and an all-encompassing plan is more your style or a “pay-as-you-go” plan fits you better?

Full-service _____ Pay-as-you-go _____ I want to learn more _____