Hearing Evaluation Services of Buffalo, Inc.
It's Good to Hear

Adult Hearing Health History

Name: _____ Date of Birth: _____ Gender: M F

Employer: _____ Occupation: _____

Primary Care Physician: _____

What is the reason for your visit (primary concern)? _____

How did you hear about us: ☐ Television ☐ Radio ☐ Phone Book ☐ Internet (Search Engine)
☐ Internet (Social Media) ☐ Mailer ☐ Family/Friend ☐ Physician ☐ Other

If other, please explain: _____

Hearing History:

Yes No Do you feel you have a hearing loss? If YES, is one ear worse? Right Left No Difference

Has your hearing loss occurred gradually or very suddenly? Gradual Sudden

When did you first notice your hearing loss? _____

Yes No Have you ever had your hearing tested? When and Results: _____

Yes No Have you ever worked in a loud place or participated in loud activities? Explain: _____

_____

Yes No Do you use hearing protection at work or during these loud activities?

Yes No Do you hear ringing or buzzing in your ears (tinnitus)?

If yes, which ear(s): Right Left Both If yes, does it bother you? Yes No

Is the tinnitus constant or occasional? Constant Occasional

When did your tinnitus begin? _____

What does your tinnitus sound like? _____

Yes No Does anyone else in your family have difficulty hearing? If yes, who? _____

Medical History:

Yes No Do you have a history of ear infections or ear surgery?

If yes, explain: _____

Yes No Have you ever seen a doctor for an ear-related issue?

If yes, name of doctor and date of visit: _____

Yes No Pain in your ears? If yes, which ear(s): Right Left Both

Yes No Drainage from your ears? If yes, which ear(s): Right Left Both

Yes No Dizziness or imbalance? If yes, is it: Constant Occasional

When did it begin and please describe? _____

Yes No Do you have any chronic medical conditions?

If yes, list: _____

(Please Complete Back of Form)

Yes No Do you have any allergies (ex. Latex, Acrylic, dyes)?

Yes	No	Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months?
		If yes, how often have you used a tobacco product in the past 24 months? _____
		If yes, what type(s) of products have you used?

Please list all your medications, vitamins, etc **(If you have this written down, we will copy it for you)**

Name *(please write legibly)*	Dosage	Frequency	Route (mouth, injection, etc.)	Reason

Your Hearing Needs: If possible, please review this with someone who lives with you or communicates with you on a frequent basis.

What motivated you to set the appointment for your hearing test? _____

What is your hearing aid experience?

☐ I have a hearing aid and use it regularly in my: ☐ Right ear ☐ Left ear ☐ Both ears

☐ I have inquired about hearing aids at another office but did not purchase at the time.

☐ I have a hearing aid, but don't use it or only use it occasionally.

☐ I have never used a hearing aid.

☐ I have tried a hearing aid but returned it.

Please list the top 3 situations you would most like to hear better. Be as specific as possible.

1. _____

2. _____

3. _____

Please rank your most important consideration regarding hearing aids with 1 as most and 4 as least important.

_____ Hearing aid size and the ability of others not to see the hearing aids

_____ Improved ability to hear and understand speech

_____ Improved ability to understand speech in noisy situations (e.g. restaurants, parties, etc.)

_____ Cost of the hearing aid system

On a scale of 1 to 10, how ready are you to get help for your hearing difficulty?

Not At All Ready **Very Ready**

1 2 3 4 **5** **6** **7** **8** **9** **10**

Signature: _____ **Date:** _____

Please bring this completed form to your appointment.