Hearing Health Assessment

Patient Name:_____ Date:_____

Primary reason for today's visit?_____

Medical History

Please circle all that apply:

Diabetes	Anxiety	Depression	Poor Eyesight
Memory Loss	Arthritis	Lymes Disease	Cancer
Radiation	Chemotherapy	Ear Surgery	Hx. of chronic ear infections
Head Injury	TMJ (clenching teeth)	Hearing loss	Dizziness
Tinnitus (ringing in ears)	Hx. of Noise Exposure	Sound sensitivity	Compromised immune system
Allergies	Excessive Earwax	Autism/ Asbergers Syndrome	Developmental Delays

Any recent changes in medications (past 90 days)?_____

Hearing History

When was your last hearing exam? _____ By Whom? _____ Results? _____

Do YOU feel that you have hearing loss?	Yes	No		
Do OTHERS complain about your hearing?	Yes	No	if yes:	Who?_____
Can you HEAR but NOT UNDERSTAND?	Yes	No		
Do you have trouble on the telephone?	Yes	No		
Do you have trouble hearing in noise?	Yes	No		

How motivated are you to improve your hearing?
(mark a spot on the line that best represents how motivated you are)

<-1----------5----------10->

NOT Motivated Very Motivated

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