

# 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