

# Hearing Health Assessment

## New Patients

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

### General History

When was your last hearing exam? \_\_\_\_\_ By whom? \_\_\_\_\_

What were the recommendations? \_\_\_\_\_

How long ago did you start to notice a decline in your hearing?

- Within past 90 days   
  1–3 years   
  4–6 years   
  7–10 years   
  10+ years

Have you ever used assistive listening devices?     Yes     No

Do you suffer from acute or chronic dizziness?     Yes     No

Has anyone in your family suffered hearing loss?     Yes     No    If yes, who? \_\_\_\_\_

### Medical History

- Diabetes                       Radiation therapy to local area                       Compromised immune system  
 Cognitive ability             Chemotherapy within 6 months                       TMJ

Allergies to any medications, plastics, etc.? \_\_\_\_\_

Current medications (i.e., blood thinners) \_\_\_\_\_

Have you ever had ear surgery?     Yes     No    If yes, which ear?     Right     Left

Type \_\_\_\_\_

Do you have regular MRIs?             Yes     No

Please list all major surgeries and illnesses (past 10 years) \_\_\_\_\_

		Right Ear	Left Ear
<b>INTERVIEW</b>	<b>Patient Experience</b>	<input type="radio"/> Poor hearing <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (past 90 days) <input type="radio"/> Excessive noise exposure	<input type="radio"/> Poor hearing <input type="radio"/> Telephone <input type="radio"/> Ringing <input type="radio"/> Pain/discomfort <input type="radio"/> Drainage (past 90 days) <input type="radio"/> Excessive noise exposure
	<b>Audiometric Range</b>	<input type="radio"/> Within range <input type="radio"/> Out of range	<input type="radio"/> Within range <input type="radio"/> Out of range
<b>EXAMINATION</b>	<b>Middle Ear &amp; Outer Ear</b>	<input type="radio"/> TM perforation <input type="radio"/> PE tube <input type="radio"/> Osteoma <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Exostosis <input type="radio"/> Cerumen buildup <input type="radio"/> Keratosis obturans <input type="radio"/> Chronic or acute drainage	<input type="radio"/> TM perforation <input type="radio"/> PE tube <input type="radio"/> Osteoma <input type="radio"/> Cholesteatoma <input type="radio"/> Malformation <input type="radio"/> Exostosis <input type="radio"/> Cerumen buildup <input type="radio"/> Keratosis obturans <input type="radio"/> Chronic or acute drainage
	<b>Skin Condition</b>	<input type="radio"/> Contact dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin; risk of trauma	<input type="radio"/> Contact dermatitis <input type="radio"/> Chronic external otitis <input type="radio"/> Thin, dry skin; risk of trauma
	<b>Ear Geometry</b>	<input type="radio"/> Too narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped	<input type="radio"/> Too narrow <input type="radio"/> Vertical step <input type="radio"/> Ant/post bulge <input type="radio"/> V-shaped

# Hearing Health Assessment

New Patients

In our professional experience, we have found that many of our patients describe hearing loss as the perception of Sound Voids, moments lacking clarity in hearing or understanding. This affects not only their normal daily routines but the lives of those around them. We would like to ask you a few situational questions to better understand your listening lifestyle and how we might improve your quality of life.

Rarely      Sometimes      Frequently

<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When using the telephone, how often are you experiencing Sound Voids?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When watching television, how often are you experiencing Sound Voids?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When in restaurants, how often are you experiencing Sound Voids?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How often are Sound Voids limiting or hampering your social or personal life?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How often do Sound Voids cause you to ask someone to repeat themselves?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When in the presence of background noise, how often are you experiencing Sound Voids?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	When listening to women's or children's voices, how often are you experiencing Sound Voids?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How often are Sound Voids causing you to hear people speak but not understand what they are saying?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How often are Sound Voids causing you to feel as though other people are mumbling?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	How often are Sound Voids causing you to feel stressed or tired after listening for long periods of time?

## Please provide the top three listening situations where you would like to hear better.

- Driving
- Family
- Meetings
- Music
- Outdoors
- Religious
- Restaurant
- Social
- Telephone
- Television
- Travel
- Other

Below are four listening lifestyles that range from frequent to rare background noise you might experience throughout your day. When you think about your daily activities, in addition to your less frequent but important activities, which lifestyle best describes you now and where you'd like to be?

## Please select your current lifestyle and your desired lifestyle.

- Active Lifestyle (Frequent Background Noise)
  - Current
  - Desired
- Casual Lifestyle (Occasional Background Noise)
  - Current
  - Desired
- Quiet Lifestyle (Limited Background Noise)
  - Current
  - Desired
- Very Quiet Lifestyle (Rare Background Noise)
  - Current
  - Desired

Notes