ChEARS, Inc.

ADULT HEARING HEALTH PROFILE

Name: _____ **Date:** _____

1.) Have you had your hearing tested before? ☐ Yes ☐ No If yes, where? _____

2.) Do you have loss of hearing in one or both ears? ☐ Right Ear ☐ Left Ear ☐ Both

3.) How long have you noticed hearing loss? ☐ Less than 1 yr ☐ 1 yr or more ☐ 5 yrs or more

4.) Have you had any surgeries or medical problems with your ears? ☐ Yes ☐ No _____

5.) Please check any of the following that apply:

☐ Tinnitus (noise in ears), ☐ Vertigo/dizziness, ☐ Facial numbness/tingling, ☐ Pain in ears,
☐ Sudden hearing loss, ☐ Ear infections/drainage, ☐ Noise exposure, ☐ Head trauma, ☐ Ear fullness
☐ Family history of hearing loss, ☐ History of headaches/migraines, ☐ Other_____

6.) Please check any of the following areas you have difficulty hearing:

☐ TV/Radio, ☐ Quiet one on one conversations, ☐ Small/large groups, ☐ Restaurants,
☐ Telephone, ☐ In the car, ☐ Church/Synagogue, ☐ Other_____

7.) Have hearing aids been recommended to you? ☐ Yes ☐ No

8.) Are you currently using hearing aids? ☐ Yes ☐ No

9.) If yes, what type of hearing aids are you using? _____

10.) Do you use your hearing aids several hours each day? ☐ Yes ☐ No (If no, why not?) _____

11.) Are you satisfied with your current hearing aids? ☐ Yes ☐ No

12.) If not satisfied, what don't you like about them? _____

_____
Patient Signature

FOR INTERNAL USE ONLY **Otoscopy ☐ Clear** **Cerumen: ☐ Right ☐ Left**

Patient Specific Needs:

1 _____ 2 _____

3 _____ 4 _____

Recommendations: _____

Outcome: _____

Previous HAs		**SN Rt**	**SN Lt**
Make:	**Model:**		
	Warranty Exp:		
	Purchase Date:		