HEARING AID SERVICES, INC.

Confidential Hearing History

Our goal is to work with you to improve your hearing. To help us address your concerns and assess your hearing requirements, please complete this questionnaire. Thank you for placing your trust in us for all your hearing needs.

Name ____ Date of Birth _____________

Address____

City ____ State _________ Zip __________________

Home phone ____________________ Work ____________________ Cell ______________________

Contact Person ______________________________________ (Relationship) __________________

Contact Person's Phone Number(s) ________________________ ______________________________

Your email address: __________________________________ Occupation: _______________________

Name of Family Doctor: ____

Will this be your first Hearing Test? ________ If no, the year you were last tested: ______________

Where were you tested? ____

Why have you decided to have your hearing tested at this time?

a) I feel my hearing is poor and may need to be aided.
b) Family/Friends have suggested I have my hearing checked.
c) Other reasons: ____

What do you believe caused your hearing problem? ____

Does a hearing problem cause tension when talking with family members? _____ yes _____no
Are there activities you avoid or have stopped doing due to your hearing? _____yes _____no
Do people seem to mumble? _____ yes _____ no
Do you find yourself frequently asking others to repeat what they have said? _____ yes _____ no
Do you find it difficult to hear in noisy places? _____ yes _____ no
Do you have difficulty hearing women or children? _____ yes _____ no

Please circle any of the following situations where you have difficulty hearing.

Conversations with 1 person Meetings Church Services

In small groups Watching TV At work

In large groups Using the Telephone Restaurants

Hearing the doorbell or telephone Movie Theaters

Other: ____

How did you hear about our company?____
____

Do you wear hearing aids in both ears? ______ Left ear only _____ Right ear only _____

What year did you buy you hearing aid(s)? ______________

Approximately how many hours a day do you wear your hearing aid(s)? __________

Do you have any concerns about the aid(s) you're currently wearing?_____________________________________

____

Medical History

Have you ever had ear surgery? ____yes ____no

Check any that apply to you:

_____ Sudden or rapid hearing loss in the past 90 days.
_____ Acute or recurring dizziness
_____ Hearing in one ear has worsened in the last 90 days.
_____ Ear Pain
_____ Tinnitus (ringing or other ear noise

_____ Arthritis
_____ Allergies
_____ Diabetes

The Communication Policy of Hearing Aid Services, Inc. is to provide excellent communication with our patients. To accomplish this, we communicate in various methods: Phone, email mail, fax, etc. It is within you right under the Federal Privacy Policy to restrict such communications.

Please read and answer the following statements:

Messages may be left on my answering machine, if I have one YES NO

Messages may be left with others, family member, etc. if they answer: YES NO

I may be called at work if that number has been provided: YES NO

Correspondences may be mailed to my home: YES NO

Please sign here: ____ Date __________________

Specialist ____ Date _________________

Notes: ____