

Hearing Care Center

301-714-4390

Name _____

Occupation _____

Referred by _____

Date _____

Reason for referral _____

1. When did you first notice the problem? _____

2. Do you know the reason for this problem? _____

3. Has it become worse? If so, explain _____

4. Do you hear better in one ear? If so, explain _____

5. Any history of hearing loss in your family? If so, explain _____

6. Do you wear a hearing aid? Yes or No

If yes, how long? _____

Is it satisfactory? Please explain _____

7. Have you ever been exposed to loud noise, recently or in the past? Yes or No (please check (v) all that apply)

- Firearms Factory work Military equipment Power tools
- Music Farm equipment Explosions Heavy equipment
- Motorcycles/recreational vehicles other _____

8. Please check (v) if you have experienced any of the following:

- Excessive ear wax Ear drainage/bleeding Swimmer's Ear
- Ear pressure/fullness Popping sensation in the ear Ear pain
- Fluctuating hearing loss Fluid behind the eardrum Dizziness/Vertigo
- Sensitivity to loud noises Tinnitus (head noises)

9. Please check (v) if you have been diagnosed with any of the following:

- Otosclerosis Cholesteatoma Sudden hearing loss
- Labyrinthitis Meniere's disease Barotrauma
- Permanent hearing loss Ossicular dislocation/fixation Acoustic neuroma
- Bell's palsy

10. Please list your current prescriptions, including vitamins, supplements, herbal remedies or over the counter:

Medication	Reason
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

*If needed, please list additional medications on a separate piece of paper.

Name _____

11. Have you ever used tobacco products of any kind? Yes or No

12. How many alcoholic drinks per week do you consume? _____

13. Please check (✓) if you have experienced any of the following

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Mumps | <input type="checkbox"/> Kidney or renal problems |
| <input type="checkbox"/> Stroke/TIA | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Chronic sinus infections |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Measles | <input type="checkbox"/> Environmental allergies |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Hypothyroidism | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Radiation/chemotherapy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Long term IV antibiotics |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Visual Problems | <input type="checkbox"/> Head trauma |
| <input type="checkbox"/> Depression or anxiety | <input type="checkbox"/> Hepatitis A, B or C | <input type="checkbox"/> Loss of consciousness |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Liver Problems | <input type="checkbox"/> Exposure to chemicals/solvents |

14. Please read through each listening situation and evaluate how well you hear. Also determine how important it is for you to hear in that situation.

	Hearing Quality					Importance to you		
	Poor				Good	Not	Somewhat	Very
Quiet (one on one conversation)	1	2	3	4	5	1	2	3
Television.....	1	2	3	4	5	1	2	3
Music.....	1	2	3	4	5	1	2	3
Leisure activities.....	1	2	3	4	5	1	2	3
Restaurants.....	1	2	3	4	5	1	2	3
Church.....	1	2	3	4	5	1	2	3
Meeting/groups.....	1	2	3	4	5	1	2	3
Work place.....	1	2	3	4	5	1	2	3
Telephone.....	1	2	3	4	5	1	2	3
Car.....	1	2	3	4	5	1	2	3
Male voice.....	1	2	3	4	5	1	2	3
Female voice.....	1	2	3	4	5	1	2	3
Child's voice.....	1	2	3	4	5	1	2	3

15. What do you hope to gain from this testing? _____