BETTER HEARING CARE

3375 Burns Road, Suite 106
Palm Beach Gardens, Florida 33410
(561) 624-7525

Name _____

Street Address _____

City_____ **State**_____ **Zip** _____

Phone: Home_____ **Cell**_____ **Work** _____

Date of Birth_____ **Age** _____ **Spouse**_____

Email address _____

Please check: Permanent Resident___ Seasonal Resident___ (if Seasonal, please see over)

Primary Care Physician: Name _____**Phone**_____

Address_____

_____

We have permission to contact your physician regarding your hearing health care:
_____Yes _____No

We have permission to send you occasional correspondence _____Yes _____No

Referred by or heard of us from: _____

Will this be your first hearing test? _____Yes _____ No Last test date _____

Have you seen a doctor in the past 6 months? _____ Yes _____ No

Have you ever had ear surgery? _____ Yes _____ No

Deformity of the ear? _____ Yes _____ No

Sudden or rapid hearing loss in the last 90 days? _____ Yes _____ No

Acute or recurring dizziness? _____ Yes _____ No

Are you experiencing any ear pain? _____ Yes _____ No

Has the hearing in one ear worsened in the last 90 days? _____ Yes _____ No

Have you ever found it necessary to have wax removed? _____ Yes _____ No

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Name: _____

PLEASE PROVIDE SEASONAL ADDRESS:

Street Address _____

City_____ State_____ Zip _____

Phone: Home_____ Cell_____ Work _____

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Name: _____

In which ear is your hearing worse? _____ Left _____ Right _____ Same

Have you noticed that people mumble? _____ Yes _____ No

Do you find that you have to ask people to repeat themselves? _____ Yes _____ No

Do you sometimes hear words but don't always understand them? _____ Yes _____ No

Do you find it difficult to hear in noisy places? _____ Yes _____ No

Have you ever been told that you speak loudly? _____ Yes _____ No

Do others complain that you set the TV too loud? _____ Yes _____ No

Do you avoid social events because of your hearing difficulty? _____ Yes _____ No

Do you find it difficult to understand speech when your back is to the speaker? ___Yes___ No

How many years have you experienced hearing difficulty? _____

Do you have a hearing aid? _____ Yes _____ No

If yes, the brand name? _____ How old_____

Do you have a pacemaker? _____ Yes _____ No

Do you have health insurance? _____ Yes _____ No

If yes, please provide us with your insurance cards so we can scan to your file.

LIST ALL MEDICINES YOU ARE CURRENTLY TAKING:

_____

_____

_____

MEDICAL WAIVER

I have been advised by my hearing care professional that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in diseases of the ear) before purchasing a hearing aid. The use of a hearing aid cannot restore hearing to normal. Improvement is based on duration and severity of impairment. Hearing aids cannot distinguish between speech and undesirable noise. I am at least 18 years of age.

Signature _____ Date _____

Better Hearing Care

Name _____ Date_____

Our goal is to maximize your ability to hear so that you can communicate more easily with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. By having a better understanding of your needs, we can use our expertise to recommend the hearing devices that are most appropriate for you. By working together, we will find the best solution.

Please complete the following questions. Be as honest and precise as possible. Thank you.

1. Please list the top three situations where you would most like to hear better. Be as specific as possible.
   a. _____
   b. _____
   c. _____

2. How important is it for you to improve your hearing right now? Mark an "X" on the line.

   Not Very Important ---------- Very Important

3. How motivated are you to wear and use hearing devices? Mark an "X" on the line.

   Not Very Important ---------- Very Important

4. How well do you think hearing devices will improve your hearing? Mark an "X" on the line.

   I expect them to:

   Not be helpful at all ---------- Greatly improve my hearing

5. What is your most important consideration regarding hearing devices? Rank order the following factors with 1 as the most important and 4 as the least important. Place and "X" on the line if the item has no importance to you at all.

   _____ Hearing device size and the ability of others not to see the hearing devices

   _____ Improved ability to hear and understand speech

   _____ Improved ability to understand speech in noisy situations (restaurants, parties)

   _____ Cost of the hearing devices

6. Any other information you want to add about your hearing or hearing aids (if you have hearing aids)?

   _____

   _____

   _____