Hearing Health Assessment

Current Hearing Technology Users

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

Do you experience acute or chronic dizziness? ○ Yes ○ No

Does your family have a history of hearing loss? ○ Yes ○ No If yes, who? _____

Medical History

○ Diabetes ○ Radiation therapy to local area ○ Compromised immune system

○ Cognitive impairment ○ Chemotherapy within 6 months ○ TMJ

Allergies to any medications, plastics, etc.? _____

Current medications _____

_____

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

Hearing Health Assessment

Current Hearing Technology Users

Current hearing technology

Brand and model of your hearing technology _____

Style of technology ○ Behind-the-Ear ○ In-the-Ear (describe) _____

Do you wear technology in both ears? ○ Yes ○ No

How many years ago did you purchase your technology? ○ 1–3 ○ 3–5 ○ 5+

My current hearing technology...

	Yes	No
Feels comfortable	☐	☐
Emits feedback or whistling noises	☐	☐
Provides hearing confidence on a day-to-day basis	☐	☐
Is cosmetically appealing	☐	☐

How often is your hearing technology's performance meeting your listening lifestyle needs?

	Frequently	Sometimes	Rarely
On the phone	☐	☐	☐
While watching TV	☐	☐	☐
In a restaurant	☐	☐	☐
In social or personal life	☐	☐	☐
In conversations with spouse or family	☐	☐	☐
In background noise	☐	☐	☐

	Frequently	Sometimes	Rarely
In conversations with women or children	☐	☐	☐
In understanding what others are saying	☐	☐	☐
In reducing the feeling that people are mumbling	☐	☐	☐
In reducing the feeling of being stressed or tired after listening for long periods of time	☐	☐	☐

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

1 _____

2 _____

3 _____

Please select your current lifestyle, and if different, please identify 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 _____