

## BETTER HEARING QUESTIONNAIRE

Our concern is your hearing and to better help you, we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs.

**Name** \_\_\_\_\_ **Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
Last First Middle Initial

**Mailing Address** \_\_\_\_\_  
Street City State Zip

**Home Phone #** \_\_\_\_\_ **Cell Phone #** \_\_\_\_\_ **Preferred Home**  **Cell**

**Social Security #** \_\_\_\_\_ **Primary Care Physician:** \_\_\_\_\_

**Email Address:** \_\_\_\_\_ **Occupation:** \_\_\_\_\_

**Sex:** Male  Female  **Marital Status:** Single  Married  Widowed  Divorced

**Insurance Plan:** \_\_\_\_\_ **Policy #** \_\_\_\_\_

**How did you hear about us?** \_\_\_\_\_ **Name of person attending appointment with you:** \_\_\_\_\_

**Reason for your visit today:** \_\_\_\_\_

### MEDICAL/AUDIOLOGIC HISTORY

	YES	NO
<ul style="list-style-type: none"> <li>▪ Will this be the first time you've had a hearing test? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            If yes, what year were you last tested _____</li> <li>▪ Have you ever had ear surgery? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            If yes, when? _____ Which ear? _____            What was the procedure? _____</li> <li>▪ Do you have noises or ringing in your ears? (Tinnitus) <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            If yes, for how long? _____</li> <li>▪ Do you have a family history of hearing loss? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></li> <li>▪ Have you ever been exposed to loud noises in your life? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span></li> <li>▪ Do you hear better in one ear over the other? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            If yes, which ear? _____</li> <li>▪ What do you believe caused your hearing problem? _____</li> <li>▪ Do you wear hearing aids? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            If yes, which ear? Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>            What year did you buy your hearing aids? _____            Do you have any problems with your hearing aids? <span style="float: right;"><input type="checkbox"/> <input type="checkbox"/></span>            If yes, please explain the problem: _____</li> <li>▪ Why have you decided to have your hearing tested at this time?  <input type="checkbox"/> I feel my hearing is poor and may need to be treated.  <input type="checkbox"/> Family/friends have suggested I have my hearing checked.  <input type="checkbox"/> Other reason/please explain: _____</li> </ul>		

(Please complete backside of form)

**MEDICAL HISTORY**

Have you had or do you currently have any of the following:

- |                     |                          |               |                          |                 |  |
|---------------------|--------------------------|---------------|--------------------------|-----------------|--|
| High blood pressure | <input type="checkbox"/> | Heart disease | <input type="checkbox"/> | Stroke          | <input type="checkbox"/>                       |
| Arthritis           | <input type="checkbox"/> | Diabetes      | <input type="checkbox"/> | Kidney disease  | <input type="checkbox"/>                       |
| Cancer              | <input type="checkbox"/> | Mumps         | <input type="checkbox"/> | Measles         | <input type="checkbox"/>                       |
| General anesthetic  | <input type="checkbox"/> | Meningitis    | <input type="checkbox"/> | Other diagnosis | <input type="checkbox"/> Please explain: _____ |

Please list any medications that you take (or attach a list to your paperwork):

---



---

**HEARING HEALTH QUESTIONNAIRE**

The onset of hearing loss is usually very gradual. It may take place over 25-30 years, or it may happen more rapidly if you are exposed to loud noises at work or through hobbies. Since it usually occurs slowly, you may not even be aware you have a problem until someone else brings it to your attention. Please answer the following questions:

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Do others complain that you watch television with the volume too high?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Do you frequently have to ask others to repeat themselves?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Do you have difficulty understanding when in groups or noisy situations?                             | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you have to sit up front in meetings or in services in order to understand?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you have trouble following the conversation when two or more people are talking at the same time? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Do you have difficulty understanding the speech of women or children?                                | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Do you feel that speech sounds are often muffled or mumbled?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does it often feel like people talk too fast?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Do you have difficulty understanding someone when they talk to you from another room?                | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Have others told you that you don't seem to hear them well?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Do you have trouble knowing where sounds are coming from?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Do you avoid family or social situations because it is a struggle to understand the conversation?   | <input type="checkbox"/> | <input type="checkbox"/> |

**MEDICAL WAIVER:**

I have been advised by Hearing Associates of Las Vegas, LLC that the Food and Drug Administration has determined that my best interest would be served if I had a medical exam by a licensed physician (i.e. ENT) before purchasing hearing aids. I do not want a medical exam by an ENT and I am at least 18 years of age.

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Thank you for helping us help you hear better!*