pacificaudiologyclinic

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Name _____ _____ _____ Date of Birth _____
(Last) (First) (Initial) (M/D/Y)

Occupation (past/present) _____ Primary Care Doctor _____

How did you hear about us? _____ Did you see our website? _____

Home phone _____ Cell phone _____ Work phone _____

Name of spouse or partner _____

Audiologic History

Describe your hearing problems

_____

How long have you noticed a hearing problem _____

What do you believe caused your hearing problem

_____

	YES	NO
Will this be the first time you've had a hearing test?	☐	☐
If no, what year were you last tested _____		
Have you ever had ear surgery?	☐	☐
If yes, when? _____ which ear? _____ type of surgery? _____		
In which ear do you hear better? ☐ left ☐ right ☐ same		
Do you have noises or ringing in your ear(s)?	☐	☐
If yes, sounds like _____ in ☐ right ear ☐ left ear ☐ both ears		
Is the ringing/sound in your ears: ☐ constant ☐ intermittent		
Did you have chronic ear infections as a child or adult?	☐	☐
Do you have drainage from your ears?	☐	☐
If yes, when did it start? _____		
Do you have pain in your ears?	☐	☐
If yes, when did it start? _____		
Do you have a family history of hearing loss?	☐	☐
If yes, who? _____ Were they BORN with a hearing loss? _____		
Have you been exposed to a lot of noise in your life?	☐	☐
If yes, what type? _____		

(see next page)

	YES	NO
Have you ever had a skull fracture/temporal bone fracture?	☐	☐
Do you feel fullness or pressure in your ears?	☐	☐
If yes, which ear? _____ How often? _____		
Do you have dizziness or vertigo?	☐	☐
If so, last episode? _____ How long did it last _____		
Do your ear canals itch?	☐	☐
Do you have sinus or allergy problems?	☐	☐
Are you currently smoking cigarettes?	☐	☐
Packs/day _____ Duration of use _____		

List any medications that you take (please include amount and dosage):

Questionnaire about your hearing

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. Please complete the front and back side and return to the front desk.

	YES	NO
Do you have difficulty hearing when someone speaks in a whisper?	☐	☐
Do you feel fullness or pressure in your ears?	☐	☐
If yes, which ear? _____ How often? _____		
Does a hearing problem cause you difficulty when visiting friends or relatives?	☐	☐
Does a hearing problem cause you to attend social gatherings less often than you would like?	☐	☐
Does a hearing problem cause you difficulty when listening to TV or radio?	☐	☐
Do you have difficulty hearing women or children?	☐	☐
Does a hearing problem cause you difficulty when in a restaurant with friends or relatives?	☐	☐
Do you feel embarrassed, frustrated and/or angry about your hearing problem?	☐	☐
Does your problem affect your family or relationships?	☐	☐
Do you have difficulty hearing on the telephone?	☐	☐
If yes, which ear do you use on the telephone? (check one) ☐ right ☐ left		
Do you wear hearing aids?	☐	☐
If yes, check one: ☐ left only ☐ right only ☐ both ears		

What year did you buy your hearing aids? _____

(see next page)

	YES	NO
Approximately how many hours a day do you wear them? _____		
Are you currently satisfied with your hearing aids?	☐	☐
Do you have any problems with your hearing aids?	☐	☐

If yes, explain: _____

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

- ☐ I feel my hearing is poor and may need to be aided.
- ☐ Family/friends have suggested I have my hearing checked.
- ☐ Other reason/explain: _____

Assessment of Priorities relating to your hearing

If you have a preference for hearing aid technology and/or style, check the appropriate boxes below.

Hearing Aid Technology

- ☐ Advanced Digital Instruments
- ☐ Programmable Instruments
- ☐ Basic Instruments
- ☐ No Preference

Hearing Aid Style

- ☐ Completely-In-the-Canal
- ☐ Canal
- ☐ In-The-Ear
- ☐ Behind-The-Ear

Indicate your ability to hear (Hearing Quality) in the following listening situations and rate the importance of that listening situation to you. Check the appropriate number based on your experiences.

Listening Situation	Hearing Quality					Importance to You		
	POOR				NORMAL	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
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
OTHER (please explain below)	☐1	☐2	☐3	☐4	☐5	☐1	☐2	☐3

Following you will find a list of important factors to consider when purchasing a hearing instrument. Please rate them in order of importance from 1 to 6 by placing the number 1 next to the most important factor, the number 2 next to the second most important factor, and so on through number 6, which is the least important factor to you.

_____ Understanding speech better
_____ Inconspicuous Appearance
_____ Comfort
_____ Function in noisy environment
_____ Cost
_____ Service

Patient Signature _____ **Date** _____