



4130 Abrams Road at Mockingbird
 Dallas, Texas 75214-2607
 214-827-1900

7615 Campbell Road At Coit # 109
 Dallas, Texas 75248-1760
 972-380-0222

Today's Date: _____
 Patient Name: _____

Date of Birth: _____

Previous and Present Medical History

Have you been examined by a physician in the past 6 months regarding your ears?yes no
 Are you taking blood thinning medication? yes no
 Do you have diabetes? yes no
 Will this be your first hearing test? yes no

If no, date of last hearing test..... _____

In which ear is your hearing worse? Left Right Same
 How did your hearing loss develop? Gradually Suddenly Past 90 days

How long have you experienced hearing difficulty? _____
 Have you ever had wax removed from your ears by a doctor? ... yes no If yes, when? _____
 Have you ever had ear surgery? yes no If yes, please explain: _____

Have you had recent ear infections? frequently rarely never childhood only
 Have you ever been exposed to loud noise in your lifetime? yes no If yes, please explain: _____

Do you know the cause of your hearing loss? yes no If yes, please explain: _____

Have you had any recent serious illness or hospitalization? yes no If yes, please explain: _____

Have you ever had kidney disease/failure? yes no Have you ever had an organ transplant? yes no
 Please list any current medications (including over-the-counter) that you are taking: _____

Do you have any of the following:

Deformity of the ear?yes no
 Acute or recurring dizziness?yes no If yes, please describe: _____

Fluctuating hearing loss?yes no
 Pain in your ears?yes no
 Sinus/Allergy problems?yes no Does it affect your hearing? Y N
 Ringing or noises in your ears?yes no If yes, which ear _____
 Family history of hearing loss?yes no
 If yes, which family members and describe their hearing loss? _____

OVER

Present Hearing Without Hearing Instruments

Do you find yourself asking people to repeat what they have said?	yes	no
Do you feel that you can hear but not understand?	yes	no
Do others complain that you turn the TV up too loud?.....	yes	no
Do you have difficulty knowing from which direction sounds are coming?	yes	no
Do you have difficulty on the telephone?	yes	no
Do you have difficulty when two or more people are talking?	yes	no
Do you have difficulty when your back is to the speaker?	yes	no
Do you avoid social events because of your hearing difficulty?	yes	no
What situation is the biggest problem you experience with your hearing?		

Do you have a hearing instrument?	yes	no
If yes, have you had a successful experience with hearing instruments?	yes	no
If not a successful experience, please explain _____		
If a hearing loss is discovered, are you ready for help?	yes	no

Priorities in Hearing Correction

Please rate the following items #1 through #6, with #1 being the MOST important and #6 being the LEAST important. **USE EACH NUMBER ONLY ONE TIME:**

_____	Understanding Speech Better
_____	Comfort
_____	Inconspicuous Appearance (size)
_____	Service
_____	Performance in noisy surroundings
_____	Price of Hearing Instruments (\$1500-\$4000/ear)

Hearing With Your Current Hearing Instruments

If you currently have hearing instruments, please respond to the following statements. In the following situations, how do you rate your hearing instrument performance: (please circle)

One-on-one conversations	Excellent / Satisfactory / Poor
Two or more speakers	Excellent / Satisfactory / Poor
Dinner conversations	Excellent / Satisfactory / Poor
Listening to TV or radio	Excellent / Satisfactory / Poor
Volume/quality of your own voice	Excellent / Satisfactory / Poor
Overall volume	Excellent / Satisfactory / Poor
Conversing outdoors	Excellent / Satisfactory / Poor
On the telephone	Excellent / Satisfactory / Poor
In a group situation	Excellent / Satisfactory / Poor
Listening to music	Excellent / Satisfactory / Poor
Comfort of fit	Excellent / Satisfactory / Poor

COMMENTS: _____

