



Do you have any of the following?

- Deformity of the ear? Yes No
- Ear drainage? Yes No
- Sudden or rapid hearing loss during the last 90 days? Yes No
- Acute or recurring dizziness? Yes No
- Ear pain? Yes No
- Wax removed by a doctor? Yes No
- Ringling in the ears? Yes No

HEARING HISTORY SURVEY:

- Do you have difficulty understanding speech in a group of people? Yes No
- Do you often ask that statements, questions and directions be repeated? Yes No
- Do you hear people speaking but have difficulty understanding the words? Yes No
- Do others raise their voices or move closer to help you hear them? Yes No
- Do you have to turn the television up louder than normal to hear clearly? Yes No
- Do you ever have to concentrate so intently to hear that you tire from it? Yes No
- Do you ever avoid situations because of your hearing problem? Yes No
- Do you have difficulty understanding conversations in a motor vehicle? Yes No
- Do you have difficulty understanding conversations on the phone? Yes No
- Do you hear some people better than others? Yes No
- Do you feel safe with your ability to hear sounds outside of your home? Yes No
- Do you have particular difficulty understanding children? Yes No

In what one situation would you most like to hear and understand? _____

If we find through the consultation that you can be helped, are you ready to move forward with that help? Yes No

Do you presently own hearing aids? Left Right Both None

If so, Make: _____ Model: _____ Year Purchased: _____

You are here today because: _____

Patient's Signature: _____

Tested by: _____ License #: _____