Central Florida HEARING SERVICES

Informative. Compassionate. Personalized.

Hearing Health Assessment

Patient Name: _____ Sex: F M Date: _____/_____/_____
First MI Last

TO BE COMPLETED BY PATIENT (PLEASE WRITE A "Y" OR "N" NEXT TO THE FOLLOWING QUESTIONS)

When was your last hearing exam? _____ By Whom? _____

How long ago did you notice a decline in your hearing? (please circle one) Within 1 year 1-5 yrs 6-10 yrs 10+ yrs
Was it gradual or sudden? _____ Right, Left or Both (circle one)
Is one ear better than the other? ____ Right or Left (circle one)
Poor speech understanding? _____
Do you notice fluctuations in your hearing? _____ Right or Left (circle one)

(PLEASE WRITE A "Y" FOR YES OR "N" FOR NO NEXT TO THE FOLLOWING QUESTIONS):
Have you ever utilized a hearing device?_____ If yes, where did you get them from? _____
Have you ever had ear surgery? _____ If yes, when: _____
Which ear: _____ Procedure: _____ Doctor: _____
Do you suffer from ear pain / discomfort? _____ Which ear: _____ Constant/Episodes (circle one)
Do you suffer from chronic ear infections? _____ Which ear: _____ Date of last infection: _____
Do your ears produce a significant amount of wax? _____ Do you have any history of ear drainage? ____ Left or Right
Have you suffered from head trauma(s)? _____ When? _____ Was it due to an automobile accident? ____
Do you experience pressure in your ears? _____ Which ear? ___ Constant/Episodes
Do you have Hypersensitivity to Noise? _____ Does one ear appear to be affected more than the other? Left or Right (circle one)
Do you suffer from dizziness/equilibrium difficulties? _____ If yes, date started? _____ attacks/constant (circle one)
Do you suffer from tinnitus (ringing in the ears)? _____ If yes, which ear? _____ constant/episodes
Date Started? _____ Any illness or medication change at the time Tinnitus(ringing) started? _____
Do you have a family history of hearing loss? _____ Father/Mother/Sibling/Grandparent (circle one)

Please circle if you have a history of any of the following:
Measles Mumps Diabetes Pneumonia Hypertension Frequent Headaches High Fevers Meningitis Memory Issues

Please circle if you have ever been exposed to excessive noise levels without hearing protection in any of the following environments?
Workplace Military Firearms Loud Music or Concerts Motorcycles or Loud Cars Lawn Mowers or Outdoor Activities
Is your dexterity (good / fair / poor)? Vision (good / fair / poor)?
Which ear do you most often use while on the phone? Right, Left, Speakerphone (circle one)
List of medications: (or provide list to front desk) _____
What is your goal for today's appointment? _____
_____.

Is there anything else you'd like to share with your provider at today's visit? _____
_____

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