Name: _____ DOB: _____ DATE:_____

GENERAL:

What is your primary reason for coming in today?_____

If you suspect a hearing loss, how long have you noticed this problem?_____

What do you feel is the cause of your hearing loss?_____

Was the onset gradual or sudden_____

In which ear do you hear the BEST? (Check one) ☐RIGHT ☐LEFT ☐BOTH are the same

Have you ever been exposed to occupational or recreational noise (EX; military, music, gun fire)? (Check one) ☐ Yes ☐ No

If yes, please describe: _____

If anyone in your family has a hearing loss, please list who:_____

Have you ever had your hearing tested? (Check one) ☐ Yes ☐ No

If yes, when?_____

MEDICAL

Have you had earaches or draining from your ears in the last 90 day? (Check one) ☐ Yes ☐ No

If yes, which ear?_____

Have you ever had medical/surgical treatment for your ears? (Check one) ☐ Yes ☐ No

If yes, at what age?_____

Do you ever have dizziness, balance problems or falls? Explain:_____

Do you notice any tinnitus (ringing, buzzing, roaring) in your ears?_____ which ear?_____

Constant or intermittent? How long have you noticed this sound?_____

Do you have any open sores, bleeding or drainage at this time? _____

Please check all that apply or that you have had in the past:

☐Chemotherapy	☐ Radiation	☐ Concussion/skull fracture
☐ Dementia/Alzheimer's	☐ Diabetes Type I, Diabetes Type II	
☐ Meningitis	☐ Pacemaker	☐ Parkinson's
☐ Scarlet fever	☐ Seizures	☐ Stroke/TIA
☐ Tuberculosis	☐ Vision problems	☐ High blood pressure

HEARING HISTORY

Do you have difficulty hearing/understanding in any of the following activities? (Check all that apply)

☐ Watching TV	☐ Restaurants meetings	☐ Telephone
☐ Movies	☐ Worship Services	

Do you have trouble hearing a: (Check all that apply)

☐ Telephone ring	☐ Doorbell	☐ Alarm Clock
☐ Fire/Smoke detector	☐ Siren	☐ Baby crying

List 3 areas where you have the most difficulty hearing or understanding

1._____

2._____

3._____

Is there any other information related to your hearing that you feel that we should know?

_____

HEARING AID HISTORY

Have you ever worn a hearing aid?_____

Do you use them now? (Check one) ☐ Yes ☐ No

If yes, now long have you had the hearing aid?_____

In which ear(s) do you wear a hearing aid? (Check one) ☐RIGHT ☐LEFT ☐BOTH

Do you wear the hearing aid(s) regularly?_____

Do you feel you benefit from the hearing aid(s)?_____

List any problems you are having with your current hearing aid_____

What would you improve with your current hearing aid?_____

Whom should we thank for referring you to St Luke's? _____

Please note: There is no charge for your hearing evaluation at this time; additional services such as hearing aid services or ear wax removal are subject to charges.