BETTER HEARING QUESTIONNAIRE

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.

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

Mailing Address_____
(City) (ST) (Zip)

Occupation (past/present) _____ **Primary Doctor:** _____

Hearing Aid Insurance/Health Plan: _____ **Policy #** _____

How did you hear about us? _____

Telephone _____ **Name of spouse or friend with you today?** _____

MEDICAL/AUDIOLOGIC HISTORY	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? _____ procedure? _____		
▪ Do you have noises or ringing in your ears?	❒	❒
▪ Did you have chronic ear infections as a child or adult?	❒	❒
▪ Do you have a family history of hearing loss?	❒	❒
▪ Have you been exposed to a lot of noise in your life?	❒	❒
▪ Have you had any trauma to the head?	❒	❒
▪ Do your ear canals itch?	❒	❒
▪ Do you have sinus or allergy problems?	❒	❒
▪ Do you have difficulty hearing when someone speaks in a whisper?	❒	❒
▪ Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	❒	❒
▪ Does a hearing problem cause you to attend church less often than you would like?	❒	❒
▪ Does a hearing problem cause you difficulty when listening to TV or radio?	❒	❒
▪ Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	❒	❒
▪ Do you have difficulty hearing women or children?	❒	❒
▪ In which ear do you hear better? circle: left right		
▪ What do you believe caused your hearing problem? _____		
▪ Do you wear hearing aids?	❒	❒
If yes, circle: left only right only both ears		
What year did you buy your hearing aids? _____		
Approximately how many hours a day do you wear them? _____		
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: _____

(Please complete backside of this form)

MEDICAL HISTORY

Have you had or currently have any of the following:

High blood pressure	Heart disease	Stroke
Arthritis	Diabetes	Kidney disease
Cancer	Mumps	Measles
Meningitis	General anesthetic	

Please list any medications that you take: _____

_____

HEARING DIFFICULTY QUESTIONNAIRE

Indicate your ability to hear (Hearing Quality) in the following listening situations and rate the importance of that listening situation to you. Circle the appropriate number in columns two and three.

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's Signature _____ **Date:** _____