HEARING AID SERVICES, INC.

Confidential Hearing History

Our goal is to work with you to improve your hearing. To help us address your concerns and assess your hearing requirements, please complete this questionnaire. Thank you for placing your trust in us for all your hearing needs.

Name _____ Date of Birth _____

Address_____

City _____ State _____ Zip _____

Home phone _____ Work _____ Cell _____

Your email address: _____ Occupation: _____

Contact Person _____ (Relationship) _____

Contact Person's Home Phone Number: _____ Cell: _____

Name of Family Doctor: _____

The Communication Policy of Hearing Aid Services, Inc. is to provide excellent communication with our patients.
To accomplish this, we communicate in various methods: Phone, email mail, fax, etc.
It is within your right under the Federal Privacy Policy to restrict such communications.

Please read and answer the following statements:

Messages may be left on my answering machine, if I have one	YES	NO
Messages may be left with others, family member, etc. if they answer:	YES	NO
I may be called at work if that number has been provided:	YES	NO
Correspondences may be mailed to my home:	YES	NO

How did you hear about Hearing Aid Services & Sales? _____
_____

Will this be your first Hearing Test? YES NO

If no, the year you were last tested: _____
Where were you tested? _____
Why have you decided to have your hearing tested at this time?

a) I feel my hearing is poor and may need to be aided.
b) Family/Friends have suggested I have my hearing checked.
c) Other reasons: _____

What do you believe caused your hearing problem? _____

Medical History

Have you ever had ear surgery?

- NO
- YES / details: _____

Check any that apply to you:

_____ Sudden or rapid hearing loss in the past 90 days.
_____ Acute or recurring dizziness
_____ Hearing in one ear has worsened in the last 90 days.
_____ Ear Infections in the last year
_____ Arthritis
_____ Allergies
_____ Diabetes
_____ Tinnitus (ringing or other ear noise)

Do you have a pacemaker, defibrillator or other active implant? _____

Do you currently wear hearing aids? YES NO

If YES:

- Do you wear hearing aids in: Both ears ____ Left ear only ____ Right ear only ____
- What year did you buy your hearing aid(s)? _____
- Approximately how many hours a day do you wear your hearing aid(s)? _____
- Do you have excessive feedback or whistling in one or both ears? _____
- Do you use a drying box daily to remove excessive moisture? _____
- Do you clean your hearing instruments thoroughly weekly? _____
- Are you satisfied with your current hearing instruments? _____
- Do you have any concerns about the aid(s) you're currently wearing? _____
  _____

If NO:

- Does a hearing problem cause tension when talking with family members? YES NO
- Are there activities you avoid or have stopped doing due to your hearing? YES NO
- Do people seem to mumble? YES NO
- Do you find yourself frequently asking others to repeat what they have said? YES NO
- Do you find it difficult to hear in noisy places? YES NO
- Do you have difficulty hearing women or children? YES NO

Please circle any of the following situations where you have difficulty hearing.

Conversations with 1-2 people	Meetings	Church Services
In small groups	Watching TV	At work
In large groups	Movie Theaters	Restaurants
Hearing the doorbell or telephone ring	Using the telephone or cell phone	

Other: _____

Client signature here: _____ Date: _____

Audiologist/Specialist signature: _____ Date _____

Special Notes: _____