**Hearing Care Center 301-714-4390**

**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Occupation \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referred by \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reason for referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When did you first notice the problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Do you know the reason for this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Has it become worse? If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
4. Do you hear better in one ear” If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. Any history of hearing loss in your family? If so, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
6. Do you wear a hearing aid? YES or NO

If yes, how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it satisfactory? Please explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been exposed to loud noise, recently or in the past? YES or NO (please check all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Firearms | Factory Work | Military equipment | Power tools |
| Music | Farm equipment | Explosions | Heavy equipment  |
| Motorcycles/recreational vehicles | Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Exp |

1. Please check if you have experience any of the following:

|  |  |  |
| --- | --- | --- |
|  Excessive ear waxExp |  Ear drainage/bleedingExp |  Swimmer’s EarExp |
|  Ear pressure/fullnessExp |  Popping sensation in the earExp |  Ear PainExp |
|  Fluctuating hearing lossExp |  Fluid behind the eardrumExp |  Dizziness/VertigoExp |
|  Sensitivity to loud noisesExp |  Tinnitus (head noises)Exp |  |

1. Please check if you have been diagnosed with any of the following:

|  |  |  |
| --- | --- | --- |
|  OtosclerosisExp | CholesteatomaExp | Sudden hearing lossExp |
| LabyrinthitisExp | Meniere’s DiseaseExp | BarotraumaExp |
| Permanent hearing lossExp | Ossicular dislocation/fixationExp | Acoustic NeuromaExp |
| Bell’s PalsyExp | COVID -19Exp |  |

1. Please list your current prescriptions, including vitamins, supplements, herbal remedies or over the counter:

|  |  |
| --- | --- |
| **Medication** | **Reason** |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| 1. **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
 | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |
| **\*If needed, please list additional medications on a separate piece of paper.\***  |

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**Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. Have you ever used tobacco products of any kind? YES or NO
2. How many alcoholic drinks per week do you consume? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Please check if you have experienced any of the following:

|  |  |  |
| --- | --- | --- |
|  Heart DiseaseExp |  MumpsExp |  Kidney or renal problemsExp |
|  Stroke/ TIAExp |  MeningitisExp |  Chronic sinus infectionsExp |
|  DiabetesExp |  MeaslesExp |  Environmental allergiesExp |
|  High Blood PressureExp |  Scarlet feverExp |  CancerExp |
|  HypothyroidismExp |  HIV/AIDSExp |  Radiation/ChemotherapyExp |
|  AsthmaExp |  TuberculosisExp |  Long term IV antibioticsExp |
|  Mental illnessExp |  Visual Problems Exp |  Head traumaExp |
|  Depression or AnxietyExp |  Hepatitis A, B or CExp |  Loss of consciousnessExp |
|  MigraineExp |  Liver ProblemsExp |  Exposure to chemicals/solvents Exp |

1. Please read through each listening situation and evaluate how well you hear. Also determine how important it is for you to hear in that situation.

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Hearing Quality** |  | **Importance to you** |
|  | Poor | Good |  | 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 |
|  |  |  |  |  |  |  |  |  |  |
| Music . . . . . . . . . . . . . . . . . . .  | 1 | 2 | 3 | 4 | 5 |  | 1 | 2 | 3 |
|  |  |  |  |  |  |  |  |  |  |
| Leisure activities . . . . . . . . . .  | 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 |
|  |  |  |  |  |  |  |  |  |  |
| Meetings/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 |

1. What do you hope to gain from this testing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2**