**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 wax  Exp | Ear drainage/bleeding  Exp | Swimmer’s Ear  Exp |
| Ear pressure/fullness  Exp | Popping sensation in the ear  Exp | Ear Pain  Exp |
| Fluctuating hearing loss  Exp | Fluid behind the eardrum  Exp | Dizziness/Vertigo  Exp |
| Sensitivity to loud noises  Exp | Tinnitus (head noises)  Exp |  |

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

|  |  |  |
| --- | --- | --- |
| Otosclerosis  Exp | Cholesteatoma  Exp | Sudden hearing loss  Exp |
| Labyrinthitis  Exp | Meniere’s Disease  Exp | Barotrauma  Exp |
| Permanent hearing loss  Exp | Ossicular dislocation/fixation  Exp | Acoustic Neuroma  Exp |
| Bell’s Palsy  Exp | COVID -19  Exp |  |

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.\*** | |

**1**

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

**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 Disease  Exp | Mumps  Exp | Kidney or renal problems  Exp |
| Stroke/ TIA  Exp | Meningitis  Exp | Chronic sinus infections  Exp |
| Diabetes  Exp | Measles  Exp | Environmental allergies  Exp |
| High Blood Pressure  Exp | Scarlet fever  Exp | Cancer  Exp |
| Hypothyroidism  Exp | HIV/AIDS  Exp | Radiation/Chemotherapy  Exp |
| Asthma  Exp | Tuberculosis  Exp | Long term IV antibiotics  Exp |
| Mental illness  Exp | Visual Problems  Exp | Head trauma  Exp |
| Depression or Anxiety  Exp | Hepatitis A, B or C  Exp | Loss of consciousness  Exp |
| Migraine  Exp | Liver Problems  Exp | 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**