

# 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?<br>If no, what year were you last tested _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Have you ever had ear surgery?<br>If yes, when? _____ which ear? _____ procedure? _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Do you have noises or ringing in your ears?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Did you have chronic ear infections as a child or adult?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Do you have a family history of hearing loss?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Have you been exposed to a lot of noise in your life?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Have you had any trauma to the head?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Do your ear canals itch?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Do you have sinus or allergy problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Do you have difficulty hearing when someone speaks in a whisper?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does a hearing problem cause you to attend church less often than you would like?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does a hearing problem cause you difficulty when listening to TV or radio?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Do you have difficulty hearing women or children?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ In which ear do you hear better? circle:            left                            right   |                          |                          |
| ▪ What do you believe caused your hearing problem? _____  |                          |                          |
| ▪ Do you wear hearing aids?<br>If yes, circle:                            left only                            right only                            both ears  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?<br>If yes, explain: _____  | <input type="checkbox"/> | <input type="checkbox"/> |
| ▪ Why have you decided to have your hearing tested at this time?<br><input type="checkbox"/> I feel my hearing is poor and may need to be aided.<br><input type="checkbox"/> Family/friends have suggested I have my hearing checked.<br><input type="checkbox"/> 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:** \_\_\_\_\_