COLUMBIA HEARING CENTERS
A Division of Columbia Surgical Specialists

Hearing Health Assessment

TO BE COMPLETED BY PATIENT

Patient Name _____ DOB _____ / _____ / _____
First MI Last MM DD YYYY

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient _____

☐ Advertisement ☐ Insurance ☐ Referred by Physician _____

☐ Consumer Seminar ☐ Other _____

What would you like to accomplish at today's appointment? _____

_____

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 5–10 Years ☐ 10+ Years

Can you attribute your hearing loss to a specific cause? ☐ Yes ☐ No If yes, what _____

Have you ever utilized hearing devices? ☐ Yes ☐ No If yes, describe your satisfaction _____

_____

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when: _____ Which ear: _____ Name of procedure: _____

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No

Do your ears produce a significant amount of wax? ☐ Yes ☐ No

Do you suffer from dizziness? ☐ Yes ☐ No

Have you had chronic ear infections? ☐ Yes ☐ No

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No

Have you ever had any trauma to the head? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No

Do you use blood thinners? ☐ Yes ☐ No

Do you have a family history of hearing loss? ☐ Yes ☐ No

Do you suffer from diabetes? ☐ Yes ☐ No

Patient dexterity ☐ Good ☐ Fair ☐ Poor

Patient vision ☐ Good ☐ Fair ☐ Poor

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawnmower ☐ Other _____

Are there any specific features you are interested in for your hearing devices? _____

_____

THIS PORTION TO BE COMPLETED BY HEARING CARE PROFESSIONAL

- ☐ Quiet Conversation
- ☐ Door Bell
- ☐ Phone Ringing
- ☐ Alarms (Clock, Security, Timers, etc.)
- ☐ Home Telephone
- ☐ Driving
- ☐ Religious Services
- ☐ Adult Conversations
- ☐ Small Family Gatherings
- ☐ Quiet Restaurants
- ☐ Cell Phones
- ☐ Shopping
- ☐ Movie Theaters
- ☐ Health Clubs
- ☐ Small Group Meetings
- ☐ Conversations with Children
- ☐ Television
- ☐ Open/Reverberant Home
- ☐ iPod®/Personal Music Players
- ☐ Outdoor Activities
- ☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)
- ☐ Busy Restaurants
- ☐ Frequent Social Gatherings
- ☐ Smartphones
- ☐ Conference Calls
- ☐ Multimedia Connectivity (Home Theater, Computer, Phone, etc.)
- ☐ Travel & Airports
- ☐ Concerts & Arts
- ☐ Group Presentations

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic **Does the companion agree?** ☐ Yes ☐ No

What are the top three environments you would like to hear better?

		SCALE OF 1–4 PRE	POST
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

NOTES: