

Ashland ENT, Allergy & Hearing Aid Center

BETTER HEARING QUESTIONNAIRE

Name _____ Date of Birth _____
(Last) (First) (Middle Initial) (M/D/Y)

Mailing Address _____
(City) (ST) (Zip)

SSN: _____ Email Address: _____

Occupation (past/present) _____ Primary Doctor: _____

Insurance/Health Plan: Please provide card at check-in. Emergency Contact: _____

How did you hear about us? AD _____ Yellow Pages _____ Ref by Physician _____ Other _____

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? ? ?
If no, what year were you last tested _____
- Have you ever had ear surgery? ? ?
If yes, when? _____ which ear? _____ procedure? _____
- Do you have noises or ringing in your ears? ? ?
- Did you have chronic ear infections as a child or adult? ? ?
- Do you have a family history of hearing loss? ? ?
- Have you been exposed to a lot of noise in your life? ? ?
- Have you had any trauma to the head? ? ?
- Do your ear canals itch? ? ?
- Do you have sinus or allergy problems? ? ?
- In which ear do you hear better? circle: left right
- What do you believe caused your hearing problem? _____
- Do you wear hearing aids? ? ?
If yes, circle: left only right only both ears
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? ? ?
If yes, explain: _____
- Why have you decided to have your hearing tested at this time?
 - Family/friends have suggested I have my hearing checked.
 - I feel my hearing is poor and may need to be aided.
 - Other reason/explain: _____

(Please complete backside of this form)

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HEARING PROBLEMS – DISCUSSION TOPICS

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.

- Tell me about your hearing problems.

- How does your problem affect your family or relationships?

- How do you feel about your hearing problem (embarrassed, frustrated, handicapped, etc.)?

- Does your hearing problem... (cause arguments, limit your personal or social life, etc.)?

- Is appearance (and/or technology) important to you? _____

- If applicable, tell me about your experience with hearing aids.

- What has triggered you to do something about your hearing loss now?

- Would you share with us a name and telephone number of a friend or relative who may have a hearing loss and benefit from our services.

Thank You for helping us help you hear better!

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Please return this form to the front desk.

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: _____

MEDICAL I have been advised by _____ AuD that the Food and Drug Administration has determined that **WAIVER** my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in disease of the ear) before purchasing a hearing instrument. I do not wish a medical evaluation before purchasing an instrument. This test information shall be compiled for the purpose of making selections and adaptations of hearing instrumentation. I am at least 18 years old.

Signature _____ Date _____

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 OR RADIO | 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.

- | | |
|---|---|
| <p>_____ Understanding speech better</p> <p>_____ Inconspicuous Appearance</p> <p>_____ Comfort</p> | <p>_____ Function in noisy environment</p> <p>_____ Cost</p> <p>_____ Service</p> |
|---|---|

What is your understanding of what hearing instruments cost?

Entry Level \$ _____ Mid-Level \$ _____ Premium \$ _____

There are payment plans available for your purchase. We accept cash, check, Visa, MasterCard, Discover and Care Credit.

Would you like to purchase your hearing instruments today (if appropriate)? _____