NELSON HEARING CLINICS

HEARING ASSESSMENT

Name _____ (First) _____ (Last) Today's date ____ / ____ / ____ (MM / DD / YYYY)

Reason for today's appointment:

_____

MEDICAL HISTORY (check any that apply)

- ☐Chemotherapy
- ☐Stroke
- ☐Diabetes
- ☐Parkinson's
- ☐Ear pain
- ☐Vision problems
- ☐Excessive earwax
- ☐Hearing loss in family
- ☐Tinnitus (noise in ears)
- ☐Memory concerns
- ☐Dizziness / imbalance
- ☐Poor dexterity
- ☐Sinus infection
- ☐Chronic ear infections
- ☐Prescription blood thinners
- ☐Radiation to head or neck
- ☐Loud noise exposure
- ☐Loud sounds feel painful
- ☐Ear-related medical treatment
- ☐Fullness / pressure in ear

Other major health concerns? Please describe.

_____

_____

HEARING HISTORY

Do you feel you have a hearing loss . . ? ☐ Yes ☐ No

If yes, is one ear worse . . . . . ? ☐ Right ☐ Left ☐ Both the same

Did the hearing loss occur . . . . ? ☐ Gradually ☐ Suddenly

When did you first notice the loss? _____

Have you ever had your hearing tested? ☐ Yes ☐ No

If yes, when and where? _____

How would *you* rate your hearing?

Worst → 1 2 3 4 5 6 7 8 9 10 ← Best

How would *your family* rate your hearing?

Worst → 1 2 3 4 5 6 7 8 9 10 ← Best

How important is it for you to hear better?

Not important → 1 2 3 4 5 6 7 8 9 10 ← Very important

How motivated are you to treat any hearing loss that is found today?

Not motivated → 1 2 3 4 5 6 7 8 9 10 ← Very motivated

Provider Notes

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HEARING ASSESSMENT

HEARING CONCERNS

Where do you notice difficulties hearing or understanding? (check any that apply)

- ☐ Watching TV
- ☐ Noisy places
- ☐ Restaurants
- ☐ Soft spoken people
- ☐ Car
- ☐ Cell phone
- ☐ Home phone
- ☐ Children
- ☐ Small groups
- ☐ Meetings / work
- ☐ Worship services
- ☐ Family gatherings

Do these difficulties cause any of the following? (check any that apply)

- ☐ Tension with loved ones
- ☐ Disagreements over TV volume
- ☐ "Zone-out" of conversations
- ☐ Feel left out of conversations
- ☐ Avoid going certain places
- ☐ Frustration / embarrassment
- ☐ No long enjoy music

Have you used any of the following to help? (check any that apply)

- ☐ Closed captions on TV
- ☐ TV listening device
- ☐ Amplified telephone
- ☐ Over-the-counter hearing aids
- ☐ Surgically implanted hearing device (i.e. Cochlear implant, BAHA)

HEARING AID HISTORY (skip section if you have never worn aid(s)

When did you first starting using hearing aid(s)? _____

For which ear(s) do you use hearing aid(s)? ☐ Right only ☐ Left only ☐ Both

How often do you currently wear aid(s)? ☐ Full-time ☐ Part-time ☐ Never

Current hearing aid(s) information:

When were the hearing aid(s) fit? _____

At what clinic where they fit? _____

Describe any concerns about current aid(s):

_____

TREATMENT OPTIONS

If aids are recommended, which options would be you interested in?

- ☐ Rechargeable batteries
- ☐ Volume control
- ☐ Wireless connection to cell phone
- ☐ Wireless connectivity with TV
- ☐ Automatic adjustments
- ☐ Smart phone app as remote control

What kind of cellphone do you use?

☐ Android ☐ iphone ☐ Flip phone ☐ No cell phone

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