Clarity Hearing
HEARING AID CENTER

Today's Date: ____________________

Please fill in accordingly, circle or check where appropriate.

1. Name____

2. Address____

____

3. Phone: _____________________Cell Phone____________________

4. Email: ______________________ ____________________

5. Age:_________ Birth Date___________________________________

6. Referred By, or how did you hear about us?_____________________

____

7. Retired? Yes No

8. Current/Former Occupation:_________________________________

9. Spouse's Name____

10. How long have you had a hearing loss_________________________

11. How long have you used hearing aids_________________________

Medical History

Do you have pain/discomfort in your ear(s)? Yes: _____ No: _____

Do you have any drainage in your ear(s)? Yes: _____ No: _____

Have you had a sudden or rapid loss of hearing in the past 90 days?

Yes: _____ No: _____

Do you have ringing or other noises in your ear(s)? Yes: _____ No: _____

Do you have acute or recurring dizziness or vertigo? Yes: _____ No: _____

Have you seen your physician regarding any of the above? Yes_____No:_____

If so, when? ____

Have you ever had **ear** surgery? Yes: _____ No: _____

Hearing History:

When was the first time you noticed difficulty hearing?

____

Have you had your hearing tested before? Yes: _____ No: ______ When:

____

Did you have a hearing Loss? Yes:_____No:_____ Mild, Moderate or Severe?

____

In which ear is your hearing the worst? Right: _____Left: _____Same: _____

Have you noticed that people seem to mumble? Yes: _____ No: _____

Do you find yourself asking people to repeat what they have said? Yes: ___No:___

Do you sometimes hear words but do not always understand them? Yes: _____
No: _____

Do you find it difficult to hear in noisy places? Yes: _____ No: _____

Have you been told that you speak loudly? Yes: _____ No: _____
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Have you been told that you turn the volume on TV up too loud?

Yes: _____ No: _____

Do you have to strain to understand young children's voices? Yes: _____ No: ____

If hearing loss is diagnosed, are you ready for help? Yes: _____ No: _____

Complete the following if you currently have a hearing aid:

How often do you wear your hearing aid(s)? ____________________

How old is/are your hearing aid(s)? ___________________

Style of hearing aid(s): _____________________________

Brand: ____________________________

Cost: _____________________________

Do you wear hearing aids in both ears Yes: _____ No: _____

Where were you fit with the hearing aid(s)?

____

When wearing your hearing aid(s), do you have difficulty understanding in crowds? Yes: _____ No: _____

Do your hearing aids make your ears sore? Yes: _____ No: _____

Do your hearing aids whistle? Yes: _____ No: _____

Do you repair your hearing aids often? Yes: _____ No: _____

What is the greatest problem with your hearing aids?

____

On a scale of 1 to 10, rate your satisfaction level with your hearing aids (1=Poor, 10=Excellent):_______