# Hearing Health Assessment

## Current Hearing Technology Users

### Current hearing technology

Brand and model of your hearing technology _____

Style of technology ○ Behind-the-Ear ○ In-the-Ear (describe) _____

Do you wear technology in both ears? ○ Yes ○ No

How many years ago did you purchase your technology? ○ 1–3 ○ 3–5 ○ 5+

### My current hearing technology...

| | Always | Sometimes | Never |
|---|---|---|---|
| Feels comfortable | A | S | N |
| Emits feedback or whistling noises | A | S | N |
| Provides hearing confidence on a day-to-day basis | A | S | N |
| Is cosmetically appealing | A | S | N |

### My current hearing technology performance is satisfactory...

| | Always | Sometimes | Never | | Always | Sometimes | Never |
|---|---|---|---|---|---|---|---|
| While in background noise | A | S | N | In a restaurant | A | S | N |
| At religious services | A | S | N | While listening to music | A | S | N |
| At the movies | A | S | N | While watching TV | A | S | N |
| In the car | A | S | N | In group conversations | A | S | N |
| On the phone | A | S | N | In conversations with spouse | A | S | N |
| In a conference room | A | S | N | In conversations with children | A | S | N |

### Please provide the top three listening situations where you would like to hear better.

1. _____

2. _____

3. _____

### Please select your current lifestyle, and, if different, please identify your desired lifestyle.

Active Lifestyle (Frequent Background Noise)
○ Current ○ Desired

Casual Lifestyle (Occasional Background Noise)
○ Current ○ Desired

Quiet Lifestyle (Limited Background Noise)
○ Current ○ Desired

Very Quiet Lifestyle (Rare Background Noise)
○ Current ○ Desired

Notes _____

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Patient Name _____ Date _____

## General History

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

What were the recommendations? _____

How long ago did you start to notice a decline in your hearing?

○ Within past 90 days ○ 1–3 years ○ 4–6 years ○ 7–10 years ○ 10+ years

Have you ever used assistive listening devices? ○ Yes ○ No

Do you suffer from acute or chronic dizziness? ○ Yes ○ No

Does your family have a history of hearing loss? ○ Yes ○ No If yes, who? _____

## Medical History

○ Diabetes ○ Radiation therapy to local area ○ Compromised immune system

○ Cognitive ability ○ Chemotherapy within 6 months ○ TMJ

Allergies to any medications, plastics, etc.? _____

Current medications (i.e., blood thinners) _____

_____

Have you ever had ear surgery? ○ Yes ○ No If yes, which ear? ○ Right ○ Left

Type _____

Do you have regular MRIs? ○ Yes ○ No

Please list all major surgeries and illnesses (past 10 years) _____

_____

| | | Right Ear | Left Ear |
|---|---|---|---|
| INTERVIEW | Patient Experience | ○ Poor hearing ○ Telephone ○ Ringing<br>○ Pain/discomfort ○ Drainage (past 90 days)<br>○ Excessive noise exposure | ○ Poor hearing ○ Telephone ○ Ringing<br>○ Pain/discomfort ○ Drainage (past 90 days)<br>○ Excessive noise exposure |
| EXAMINATION | Audiometric Range | ○ Within range ○ Out of range | ○ Within range ○ Out of range |
| | Middle Ear & Outer Ear | ○ TM perforation ○ PE tube ○ Osteoma<br>○ Cholesteatoma ○ Malformation ○ Exostosis<br>○ Cerumen buildup ○ Keratosis obturans<br>○ Chronic or acute drainage | ○ TM perforation ○ PE tube ○ Osteoma<br>○ Cholesteatoma ○ Malformation ○ Exostosis<br>○ Cerumen buildup ○ Keratosis obturans<br>○ Chronic or acute drainage |
| | Skin Condition | ○ Contact dermatitis ○ Chronic external otitis<br>○ Thin, dry skin; risk of trauma | ○ Contact dermatitis ○ Chronic external otitis<br>○ Thin, dry skin; risk of trauma |
| | Ear Geometry | ○ Too narrow ○ Vertical step<br>○ Ant/post bulge ○ V-shaped | ○ Too narrow ○ Vertical step<br>○ Ant/post bulge ○ V-shaped |