# HEARING HEALTH ASSESSMENT

**NEW PATIENT**

**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? ○ Last 90 days ○ 1-3 years ○ 4-6 years ○ 7-10 years ○ 10+years

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

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

Has anyone in your family suffered hearing loss? ○ Yes ○ No If yes, who? _____

Do you hear ringing or buzzing in either or both of your ears? ○Yes ○No If yes, how often?_____

Do you experience ear pain? ○Yes ○No If yes, how often?_____Drainage? _____

Have you ever experienced noise exposure? (i.e., military, hunting, job exposure) ○ Yes ○ No Explain _____

Have you been injured in a fall or fallen 2 or more times without injury in the past 12 months? ○ Yes ○ No If yes, when?_____

Have you had a Fall Risk Assessment completed? ○ Yes ○ No If yes when and by whom?_____

## MEDICAL HISTORY (Check all that apply)

| | | | |
|---|---|---|---|
| ○ Cancer | ○ Dementia | ○ High blood pressure | ○ Tobacco Use |
| ○ Cardiac disease | ○ Diabetes | ○ HIV | ○ TMJ |
| ○ Chemotherapy within 6 months | ○ Ear infections | ○ Radiation therapy to local area | ○ Visual trouble/double vision |
| ○ Cognitive ability | ○ Head injury | ○ Sinus/allergies | |
| ○ Compromised immune system | ○ Hepatitis | ○ Stroke/TIA(Transient Ischemic Attack) | |

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 or other known diseases (past 10 years) _____

_____

(Attach here)

## FOR AUDIOLOGIST USE ONLY

| | Right Ear | Left Ear |
|---|---|---|
| **Patient Experience** | ○Poor Hearing ○Telephone ○Ringing ○Pain/discomfort ○Drainage (past 90 days) ○Excessive noise exposure | ○Poor Hearing ○Telephone ○Ringing ○Pain/discomfort ○Drainage (past 90 days) ○Excessive noise exposure |
| **Audiometric Range** | ○Within range ○Out of range | ○Within range ○Out of range |
| **Middle Ear & Outer Ear** | ○TM perforation ○PE tube ○Osteoma ○Cholesteatoma ○Malformation ○Exostosis ○Cerumen buildup ○Keratosis obturans ○Chronic or acute drainage | ○TM perforation ○PE tube ○Osteoma ○Cholesteatoma ○Malformation ○Exostosis ○Cerumen buildup ○Keratosis obturans ○Chronic or acute drainage |

# HEARING HEALTH ASSESSMENT

**NEW PATIENT**

| | | |
|---|---|---|
| **Screenings** | ○History of Falls ○Fall Risk Assessment | ○Tabacco Use |