STONE AUDIOLOGY

# ADULT HEARING HEALTH PROFILE

Name: _____ Date: _____

1. Have you had your hearing tested before? ☐ Yes ☐ No If yes, where? _____
2. Do you have loss of hearing in one or both ears? ☐ Right Ear ☐ Left Ear ☐ Both
3. How long have you noticed hearing loss? ☐ 5 years/more ☐ Less than 1 year ☐ Over 1 year ☐ Less than 90 days
4. Do you have any pain or discomfort in your ears? ☐ Yes ☐ No _____
5. Have you had any surgeries or medical problems with your ears? ☐ Yes ☐ No _____
   Any drainage from your ears? ☐ Yes ☐ No _____
6. Do you have any noises or ringing in your ears? ☐ Yes ☐ No _____
7. Have you had any recent (within 90 days) dizziness or difficulties with your balance? ☐ Yes ☐ No _____
8. Is there a history of hearing loss in your family ☐ Yes ☐ No _____
9. Are you/have you been exposed to loud noise for extended periods of time? ☐ Yes ☐ No _____
10. Please list any previous or current medical conditions for which you are being treated:
    _____
11. Please list all medications:
    _____
12. Have hearing aids been recommended to you or are you currently using hearing aids? ☐ Yes ☐ No
13. What type of hearing aids are you using: Right Ear _____ Left Ear_____
14. Do you use your hearing aids several hours each day: ☐ Yes ☐ No (If not, why not? _____
15. Describe your experience with current hearing aids: ☐ Satisfied ☐Dissatisfied ☐Undecided
16. Comments or questions: _____

Patient Signature: _____

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**FOR INTERNAL USE ONLY** **Otoscopy: ☐ Clear** **Cerumen: ☐ Right ☐ Left**

**Diagnosis and Findings: (Identify previous diagnosis)**

_____

**Patient Specific needs/PD Details:** _____

**(Prioritize 3 main listening environments for SAC & Cosmetic, tech, cost)**

_____

**Recommendation:**

**Product:** _____ **Color:** _____ **Receiver:**_____ **Price:** _____

**Outcome: ☐ Pursue Recommendation ☐ Will Consider Recommendation ☐ Will not pursue recommendation due to:**

_____

**Professional Signature:** _____ **Date:** _____