HearAgainAmerica
Experience the Joy of Hearing

PATIENT INFORMATION

Date _____ Cell Phone _____ Home Phone _____

Name _____ **Age** _____ Birth Date _____

Spouse's Name _____

Patient ❍ male ❍ female

Address _____

City _____

State _____ Zip _____

Email Address _____

Current or Previous Occupation

_____

How did you hear about us?

❍ Word-of-mouth ❍ Physician ❍ Yellow Pages
❍ Newspaper ❍ Mailing ❍ Referral
❍ Internet ❍ Other _____

CONFIDENTIAL PATIENT INFORMATION

MEDICAL HISTORY

Have you had your hearing examined? ❍ Yes ❍ No

If yes, where _____

Have you had ear surgery? ❍ Yes ❍ No

Does anyone in your family have a hearing problem? ❍ Yes ❍ No

Who encouraged you to come see a hearing professional? _____

Have you ever found it necessary to have a doctor remove wax from your ears? ❍ Yes ❍ No

Do you feel one ear hears better than the other? ❍ Left ❍ Right

Is there a history of diabetes in the family? ❍ Yes ❍ No

Are you taking any blood thinning medication? **Type** _____ ❍ Yes ❍ No

HEARING HISTORY

Have you noticed that people seem to mumble? ❍ 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 you speak loudly? ❍ Yes ❍ No

Do others complain that you play the TV too loudly? ❍ Yes ❍ No

Have you been told on occasion that you missed the ringing of the telephone? ❍ Yes ❍ No

If a hearing loss is discovered, are you ready for help? ❍ Yes ❍ No

CONFIDENTIAL PATIENT INFORMATION

HEARING NEEDS ASSESSMENT

Put a "1" before the FIRST thing that is most important to you in purchasing a hearing aid. Now put a "2" before the SECOND most important thing to you when purchasing a hearing aid. Next put a "3" before the THIRD most important thing to you when purchasing a hearing aid. Lastly, put a "4" before the LEAST important thing to you when purchasing a hearing aid.

These are your choices:

Appearance _____ Sound Quality & Clarity _____ Durability/Reliability _____ Cost _____

MOTIVATION SCALE: On a scale of 1-10, where do you feel that you are, regarding doing something about your hearing loss? (circle one)

Not Motivated 1 2 3 4 5 6 7 8 9 10 **Very Motivated**

SPEECH UNDERSTANDING ASSESSMENT

TINNITUS - Do you have ringing (tinnitus) in your ears

1. Is your tinnitus in your ❍ LEFT EAR ❍ RIGHT EAR ❍ BOTH EARS
2. Which option best describes the head noise you are experiencing? ❍ HIGH PITCHED ❍ LOW PITCHED ❍ CRICKETS ❍ LOCUST ❍ OTHER: _____
3. Describe the loudness of your tinnitus? _____

❍ VERY LOUD ❍ LOUD ❍ MODERATE ❍ FAINT ❍ VERY FAINT

4. Is your tinnitus: ❍ CONTINUOUS ❍ INTERMITTENT
5. When did the tinnitus start? _____
6. How much is your tinnitus affecting your daily life?

❍ NOT AT ALL ❍ MILD ❍ MODERATE ❍ SEVERE

HEARING AID EXPERIENCE

❍ I have a hearing aid and use it regularly in my ___ RIGHT EAR ___ LEFT EAR

❍ I have a hearing aid, but don't use it, or use it occasionally.

❍ I have tried a hearing aid, but returned it.

❍ I have inquired about hearing aids from another office, but did not purchase.

❍ I have never tried a hearing aid.

HIPAA Acknowledgement: By signing below, I acknowledge that I received a copy of Hear Again America's Notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

*Signature of Patient or Guarantor:*_____ *Date:* _____

OFFICE USE ONLY

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