Helping hUh ear

Family Hearing Specialists, LLC

Phone: 308-532-1880
1220 S. Willow
North Platte, Ne 69101

Sherri Dodson, BC-HIS; Owner
Board Certified in Hearing Instrument Sciences
License # 631

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Board Certified in Hearing Instrument Sciences
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Hearing Case History

General Information:

Date: _____

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: _____ **Cell Phone:** _____

Email address: _____ **Date of Birth:** _____

Occupation/Retired from: _____

Family Physician: _____

Emergency Contact: _____ **Emergency Phone:** _____

Relationship of Emergency Contact: _____

How did you learn of our services?: _____

How may we contact you with reminders for check-ups and promotions? (please mark all that apply)

Phone? ☐ **Text?** ☐ **Mail?** ☐ **Email?** ☐

If we can contact you by Phone and Text, which do you prefer? Phone? ☐ **Text?** ☐

Medical Information:

Have you ever had your hearing evaluated? **Y** **N**

When: _____ **Where:** _____

Have you had drainage from your ears in the last 90 days?	**YES**	**NO**
Do you have pain or discomfort in your ears?	**YES**	**NO**
Do you have a feeling of fullness in your ears?	**YES**	**NO**
Have you had a sudden hearing loss in the last 90 days?	**YES**	**NO**
Is there a unilateral hearing loss of sudden or recent onset within the last 90 days?	**YES**	**NO**
Have you had any excessive noise exposure?	**YES**	**NO**
Do you have any family history of hearing loss?	**YES**	**NO**
Have you experienced any acute or chronic dizziness?	**YES**	**NO**
Were you ever in the Service?	**YES**	**NO**

Have you had any medical treatment or surgery on your ears? **Y** **N**

If yes, when and what reason? _____

Hearing History:

Does your hearing?

Make it difficult to talk on the phone?	**Always**	**Sometimes**	**Never**
Cause others to complain the TV is too loud?	**Always**	**Sometimes**	**Never**
Make it hard to follow conversation in restaurants?	**Always**	**Sometimes**	**Never**
Limit your social life?	**Always**	**Sometimes**	**Never**
Cause you to ask people to repeat?	**Always**	**Sometimes**	**Never**
Cause difficulty hearing women's/children's voices?	**Always**	**Sometimes**	**Never**
Cause you to hear people, but fail to understand what they are saying?	**Always**	**Sometimes**	**Never**
Cause you to feel that others mumble?	**Always**	**Sometimes**	**Never**
Cause you to feel stressed or tired after listening for long periods of time?	**Always**	**Sometimes**	**Never**

Do you have tinnitus (ringing in ears)? **Y** **N**

If yes, Right _____ **Left**_____ **Both** _____ **How long have you had tinnitus?** _____

What ear do you prefer to use on the phone? _____

Hobbies/Activities: _____

_____

If we can help you hear and understand better are you ready to accept help with hearing instruments?

Yes_____ **No**_____ **Maybe**_____

WAIVER OF MEDICAL EVALUATION FOR HEARING

I have been advised by Family Hearing Specialists, LLC that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid.

I do not wish to have a medical evaluation before purchasing a hearing aid.

Signature_____ Date_____

Advised by: _____

Hearing Aid Specialist

TO BE COMPLETED BY SPECIALIST

Any visible congenital or traumatic deformity of the ear?	**YES**	**NO**
Any visible evidence of significant cerumen accumulation or a foreign body in the ear canal?	**YES**	**NO**
Audiometric air-bone gap equal to or greater than 15db at 500Hz, 1000Hz, or 2000Hz?	**YES**	**NO**