Desert Hearing Care

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BETTER HEARING QUESTIONNAIRE

Our concern is your hearing and to better help you we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs. Please complete the front and back side and return to the front desk.

Name _____ **Birth Date** _____
(Last) (First) (Middle Initial) (MM/DD/YY)

Local Mailing Address_____
(Address) (City) (ST) (Zip)

Are you a winter resident? _____ **If yes, name of park/community?** _____

Permanent Home: City: _____**State:**_____ **Email Address:** _____

Occupation (past/present) _____ **Local Doctor:** _____

Hearing Aid Insurance/Health Plan: _____ **(Give your card to the front desk person)**

How did you hear about us? Circle all that apply: Family Friend Physician Google Bing Facebook DHC Website Display-Ad Flyer Letter Other _____

Local Telephone _____ **Name of spouse or friend with you today?** _____

MEDICAL/AUDIOLOGIC HISTORY	YES	NO
▪ Will this be the first time you've had a hearing test?	❒	❒
If no, what year were you last tested _____		
▪ Have you ever had ear surgery?	❒	❒
If yes, when? _____ which ear? _____ procedure? _____		
▪ Do you have noises or ringing in your ears?	❒	❒
▪ Did you have chronic ear infections as a child or adult?	❒	❒
▪ Do you have a family history of hearing loss?	❒	❒
▪ Have you been exposed to a lot of noise in your life?	❒	❒
▪ Have you had any trauma to the head?	❒	❒
▪ Do your ear canals itch?	❒	❒
▪ Do you have sinus or allergy problems?	❒	❒
▪ In which ear do you hear better? circle: left right		
▪ What do you believe caused your hearing problem? _____		
▪ When did you first notice your hearing loss? _____		
▪ Do you wear hearing aids?	❒	❒
If yes, circle: left only right only both ears		
What year did you buy your hearing aids? _____		
Approximately how many hours a day do you wear them? _____		
Do you have any problems with your hearing aids?	❒	❒
If yes, explain: _____		

▪ Why have you decided to have your hearing tested at this time?
- ❒ I feel my hearing is poor and may need to be aided.
- ❒ Family/friends have suggested I have my hearing checked.
- ❒ Other reason/explain:_____

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MEDICAL HISTORY

Have you had or currently have any of the following:

High blood pressure	Heart disease	Stroke
Arthritis	Diabetes	Kidney disease
Cancer	Mumps	Measles
Meningitis	General anesthetic	

Please list any medications that you take: _____

_____

HEARING DIFFICULTY QUESTIONNAIRE

Indicate your ability to hear (Hearing Quality) in the following listening situations and rate the importance of that listening situation to you. Circle the appropriate number in columns two and three.

LISTENING SITUATION	HEARING QUALITY					IMPORTANCE TO YOU		
	POOR				NORMAL	NOT	SOMEWHAT	VERY
QUIET (one on one conversation)	1	2	3	4	5	1	2	3
TELEVISION OR RADIO	1	2	3	4	5	1	2	3
RESTAURANTS	1	2	3	4	5	1	2	3
CHURCH	1	2	3	4	5	1	2	3
MEETING/GROUPS	1	2	3	4	5	1	2	3
WORK PLACE	1	2	3	4	5	1	2	3
TELEPHONE	1	2	3	4	5	1	2	3
CAR	1	2	3	4	5	1	2	3
MALE VOICE	1	2	3	4	5	1	2	3
FEMALE VOICE	1	2	3	4	5	1	2	3
CHILD'S VOICE	1	2	3	4	5	1	2	3
OTHER (please explain below)	1	2	3	4	5	1	2	3

_____

_____

NOTICE OF PRIVACY PRACTICES

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Patient Signature Date

PERMISSION TO RELEASE RECORDS:

We feel it is important for your physician and/or insurance company to have hearing related information for your medical records. By signing this form you are providing us permission to send a copy to your physician and/or insurance company. This release will be in effect until we receive written notice from you requesting we may no longer forward this information.

_____ _____

Patient Signature Date

Thank You for helping us help you hear better!