SANTA CRUZ
EAR, NOSE & THROAT
HEARING AID CENTER
www.scentmd.com

Hearing Health Assessment

Patient Name ______________________________ Sex ☐ M ☐ F Date ____/____/________
First Last MI MM DD YYYY

Address ____
Street City State Zip

Home Phone ______________________ Cell Phone ______________________

Email ______________________ SSN ______________________

Date of Birth ______________________ Marital Status ☐ Married ☐ Single

Emergency Contact ______________________ Phone ______________________

Relationship to Patient ____

Primary Care Physician ______________________ Phone ______________________

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient ______________________

☐ Advertisement ☐ Insurance ☐ Referred by Physician ______________________

☐ Consumer Seminar ☐ Employer ☐ Other ______________________

PLEASE READ CAREFULLY, CHECK THE BOXES AND SIGN BELOW

☐ I agree that I am ultimately responsible for the balance of my account for services rendered.

☐ I acknowledge that I have received the Health Insurance Portability and Accountability Act policy for this office.

☐ I give permission to this practice to release information, verbal and written, contained in my medical record and other related information to my insurance company, healthcare providers, employers, assignees and/or beneficiaries, and all other related persons. Information without patient identifiers may be used for quality purposes.

☐ The FDA has determined that it is in my best interest to have a medical evaluation by a licensed physician (preferrably a physician who specializes in diseases of the ear) before purchasing hearing devices. I have been advised by the practice and/or its agents about this determination and hereby waive this requirement.

☐ I give permission to receive newsletters or information about upcoming events, specials, and articles pertaining to services or products in the clinic.

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

I have read, understand, and agree to the above information.

____ ______________________
Patient Signature Date

____ ______________________
Legal Guardian if Patient is a Minor Date

TO BE COMPLETED BY PATIENT

When was your last hearing exam? ______________________ By whom? ______________________

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 5–10 Years ☐ 10+ Years

Have you ever utilized a hearing solution? ☐ Yes ☐ No If yes, describe your satisfaction ______________________

In which ear is your hearing the poorest? ☐ R ☐ L ☐ Both ☐ Neither

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when:_________ Which ear:______ Name of procedure:______________________

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No

Do your ears produce a significant amount of wax? ☐ Yes ☐ No

Have you had chronic ear infections as a child or adult? ☐ Yes ☐ No

Have you ever had any trauma to the head? ☐ Yes ☐ No

Do you have a family history of hearing loss? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No

Patient dexterity ☐ Good ☐ Fair ☐ Poor

Patient vision ☐ Good ☐ Fair ☐ Poor

Do you suffer from dizziness? ☐ Yes ☐ No

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawnmower ☐ Other ______________

What would you like to accomplish at today's appointment? ______________________

____

THIS PORTION TO BE COMPLETED BY HEARING CARE PROFESSIONAL

☐ Quiet Conversation	☐ Home Telephone	☐ Cell Phones	☐ Outdoor Activities
☐ Door Bell	☐ Driving	☐ Shopping	☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)
☐ Phone Ringing	☐ Religious Services	☐ Movie Theaters	☐ Busy Restaurants
☐ Alarms (Clock, Security, Timers, etc.)	☐ Adult Conversations	☐ Health Clubs	☐ Frequent Social Gatherings
	☐ Small Family Gatherings	☐ Small Group Meetings	☐ Bluetooth® Phones
	☐ Quiet Restaurants	☐ Conversations with Children	☐ Conference Calls
		☐ Television	☐ Multimedia Connectivity (Home Theater, Computer, Phone, etc.)
		☐ Open/Reverberant Home	☐ Travel & Airports
		☐ iPod®/Personal Music Players	☐ Concerts & Arts
			☐ Group Presentations
Total _______	Total x2 _______	Total x3 _______	Total x4 _______ Grand Total _______

Does the companion agree? ☐ Yes ☐ No Explain ______________________

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic

What are the top 3-5 environments you would like to hear better in?

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

Are there any specific features you are interested in for your hearing devices? ______________________