Confidential Client Information

① Patient Information

Name _____ Phone ( ) _____

Address _____ Date of Birth _____ Age _____

City _____ State _____ Zip _____

E-mail _____ Marital Status: Single Widowed Married

How did you hear about us? Patient Referral Newspaper Direct Mail Television Physician Referral Yellow Pages Website

② Medical History

Name of Primary Care or Referring Physician _____

Physician's telephone number _____ Fax _____

Have you ever had ear surgery? ☐ Yes ☐ No By whom? _____

Have you ever had your hearing tested? ☐ Yes ☐ No By whom? _____

Is there a history of diabetes in your family? ☐ Yes ☐ No How many prescription drugs do you take daily? _____

Are you taking blood thinners? ☐ Yes ☐ No Do you wear a pacemaker? ☐ Yes ☐ No

③ About Your Hearing

Do you have any of these symptoms?

☐ Yes ☐ No Deformity of the ears?

☐ Yes ☐ No Do you have any pain in your ears?

☐ Yes ☐ No Sudden or rapid hearing loss in the past 90 days?

☐ Yes ☐ No Sudden or long-term dizziness?

☐ Yes ☐ No Hearing loss in one ear in the last 90 days?

☐ Yes ☐ No Have you seen a doctor for wax removal?

☐ Yes ☐ No Drainage from either ear in the past 90 days?

Which is your poorer ear? ☐ Right ☐ Left ☐ Same

Does anyone else in your family have a hearing problem? ☐ Yes ☐ No Relationship to you? _____

In what situation does your hearing problem give you the most trouble? _____

④ Motivation

What motivated you to come in today? _____

_____

⑤ 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 only occasionally.

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

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

Please complete back side →

⑥ 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:

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

⑦ Motivation Scale

On a scale of 1-10, where do you feel that you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

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

⑧ Tinnitus

Do you have ringing (tinnitus) in your ears? ❑ **No** (if "No", move to Section 9) ❑ **Yes** (if "Yes", answer 1 - 5 below)

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? _____

⑨ Self Questionnaire

Please answer "yes," "no" or "sometimes" to each of the following items. Don't skip a question if you avoid a situation because of a hearing problem. If you wear a hearing aid(s), answer the way you hear **without** the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	❑	❑	❑
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	❑	❑	❑
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	❑	❑	❑
4. Does your hearing problem cause you to attend social events or religious services less often than you'd like?	❑	❑	❑
5. Does your hearing problem cause you to become fatigued by the end of the day?	❑	❑	❑
6. Does your hearing problem cause you difficulty when listening to TV or radio?	❑	❑	❑
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	❑	❑	❑
8. Does your hearing problem cause you to have arguments with family members?	❑	❑	❑