



4130 Abrams Road
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7615 Campbell Road, Suite 109
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10611 Garland Road, Suite 106
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5462 Glen Lakes Drive
Dallas, TX 75231
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Today's Date: _____

Patient Name: _____

Date of Birth: _____

Previous and Present Medical History

Have you been examined by a physician in the past 6 months regarding your ears? yes no

Are you taking blood thinning medication? yes no

Do you have diabetes? yes no

Will this be your first hearing test? yes no

If no, date of last hearing test _____

In which ear is your hearing worse? Left Right Same

How did your hearing loss develop? Gradually Suddenly Past 90 days

How long have you experienced hearing difficulty?

Have you ever had wax removed from your ears by a doctor? ... yes no If yes, when? _____

Have you ever had ear surgery? yes no If yes, please explain: _____

Have you had recent ear infections? frequently rarely never childhood

Have you ever been exposed to loud noise in your lifetime? yes no If yes, please explain: _____

Do you know the cause of your hearing loss? yes no If yes, please explain: _____

Have you had any recent serious illness or hospitalization? yes no If yes, please explain: _____

Have you ever had kidney disease/failure?..... yes no

Have you ever had an organ transplant?..... yes no

Please list any current medications (including over-the-counter) that you are taking:

Do you have any of the following:

Deformity of the ear? yes no

Acute or recurring dizziness? yes no If yes, please describe: _____

Fluctuating hearing loss? yes no

Pain in your ears? yes no

Sinus/Allergy problems? yes no Does it affect your hearing? Y N

Ringing or noises in your ears? yes no If yes, which ear _____

Family history of hearing loss? yes no

If yes, which family members and describe their hearing loss? _____

OVER



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Present Hearing Without Hearing Instruments

Do you find yourself asking people to repeat what they have said? yes no

Do you feel that you can hear but not understand? yes no

Do others complain that you turn the TV up too loud?..... yes no

Do you have difficulty knowing from which direction sounds are coming? yes no

Do you have difficulty on the telephone? yes no

Do you have difficulty when two or more people are talking? yes no

Do you have difficulty when your back is to the speaker? yes no

Do you avoid social events because of your hearing difficulty? yes no

What situation is the biggest problem you experience with your hearing?

Do you have a hearing instrument? yes no

If yes, have you had a successful experience with hearing instruments? yes no

If not a successful experience, please explain _____

If a hearing loss is discovered, are you ready for help? yes no

Priorities in Hearing Correction

Please rate the following items #1 through #6, with #1 being the MOST important and #6 being the LEAST important. **USE EACH NUMBER ONLY ONE TIME:**

_____ Understanding Speech Better	_____ Comfort
_____ Inconspicuous Appearance (size)	_____ Service
_____ Performance in noisy surroundings	
_____ Price of Hearing Instruments (\$1500-\$4000/ear)	

Hearing With Your Current Hearing Instruments

If you currently have hearing instruments, please respond to the following statements.
In the following situations, how do you rate your hearing instrument performance: (please circle)

One-on-one conversations	Excellent / Satisfactory / Poor
Two or more speakers	Excellent / Satisfactory / Poor
Dinner conversations	Excellent / Satisfactory / Poor
Listening to TV or radio	Excellent / Satisfactory / Poor
Volume/quality of your own voice	Excellent / Satisfactory / Poor
Overall volume	Excellent / Satisfactory / Poor
Conversing outdoors	Excellent / Satisfactory / Poor
On the telephone	Excellent / Satisfactory / Poor
In a group situation	Excellent / Satisfactory / Poor
Listening to music	Excellent / Satisfactory / Poor
Comfort of fit	Excellent / Satisfactory / Poor

COMMENTS: _____