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HEARING HEALTH SELF-ASSESSMENT

Patient Name Today’s Date Date of Birth

Address Home Phone Number Cell Phone Email

Have you ever had a hearing exam?....................................................................................................................................... Yes  No

If yes, when was your last hearing exam? 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 device?  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 when using the phone?  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

Rate your dexterity.................................................................................................................................................. Good  Fair  Poor

Rate your vision....................................................................................................................................................... Good  Fair  Poor

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?

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?

# THIS PORTION TO BE COMPLETED BY HEARING CARE PROFESSIONAL

**SOCIAL ACTIVE**

* Small Group Gatherings  Meetings
* Driving  Presentations/Seminars
* Health Clubs  Outdoor Activities
* Quiet Office  Movies
	+ Quiet Restaurants
	+ Shopping

Total x2

Total x3

**QUIET**

* Home Activities
* TV and Telephone Use
* Casual Conversation
* Quiet Music
* Door Bell
* Alarms

(Clock, Security, Timers, etc.)

Total

**DYNAMIC**

* Busy Office
* Busy Restaurants
* Multimedia Connectivity
* Concerts
* Parties
* Events

Total x4

Grand Total