



East Valley Hearing Center

"Professional Service with a Caring Touch"

a member of AUDIGY GROUP[®]

6262 E. Broadway Rd., Ste. 103
Mesa, Arizona 85206
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Hearing Health Assessment

Current Technology Users

Name: _____ Date: _____

GENERAL HISTORY

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

What were the recommendations? _____

How long ago did you notice a decline in your hearing?

- Within past 90 days
- 1-3 years
- 4-6 years
- 7-10 years
- 10+ years

Have you ever used assistive listening devices? Yes No

Do you suffer from acute or chronic dizziness? Yes No

Do you have ringing/buzzing in the ears (tinnitus)? Yes No

Has anyone in your family suffered hearing loss? Yes No If yes, whom? _____

Have you been exposed to loud noises (guns, tools, music, etc)? Yes No If yes, what? _____

MEDICAL HISTORY

- Diabetes
- Radiation therapy to local area
- Compromised immune system
- Cognitive ability
- Chemotherapy within 6 months
- TMJ
- Ear pain
- Drainage from the ears

Allergies to any medications, plastics, etc? _____

Current medications (ie: blood thinners): _____

Have you ever had ear surgery? Yes No If yes, which ear? Right Left Type: _____

Have you had an MRI? Yes No

Please list all major surgeries and illnesses: _____

(past 10 years) _____

RIGHT EAR

LEFT EAR

Audiometric Range

- Within range
- Out of range

- Within range
- Out of range

Middle Ear & Outer Ear

- TM perforation
- PE tube
- Osteoma
- Cholesteatoma
- Malformation
- Exostosis
- Cerumen buildup
- Keratosis obturans
- Chronic or acute drainage

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Skin Condition

- Contact dermatitis
- Chronic external otitis
- Thin, dry skin, risk of trauma

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Ear Geometry

- Too narrow
- Vertical step
- Ant/post bulge
- V-shaped

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FILL IN BOX ONLY

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Current Technology Users

Current Hearing Technology

Brand and model of your hearing technology: _____

Style of technology: Behind the Ear In the Ear, describe _____

Do you use technology in both ears? Yes No

How many years ago did you purchase your technology? 1-3 years 3-5 years 5+ years

My current hearing technology:

	Always	Sometimes	Never
Feels comfortable	1	2	3
Does not emit feedback or whistling noises	1	2	3
Provides hearing confidence on a day-to-day basis	1	2	3
Is cosmetically appealing	1	2	3

My current hearing technology performance is satisfactory:

	Always	Sometimes	Never		Always	Sometimes	Never
While in background noise	1	2	3	In a restaurant	1	2	3
At religious services	1	2	3	While listening to music	1	2	3
At the movies	1	2	3	While watching TV	1	2	3
In the car	1	2	3	In group conversations	1	2	3
On the phone	1	2	3	In conversations with spouse	1	2	3
In a conference room	1	2	3	In conversations with children	1	2	3

Please select your current lifestyle and if different, please select your desired lifestyle:

Active Lifestyle (Frequent Background Noise) Current Desired **Quiet Lifestyle** (Limited Background Noise) Current Desired

Casual Lifestyle (Occasional Background Noise) Current Desired **Very Quiet Lifestyle** (Rare Background Noise) Current Desired

Listening Environments

Check activities you currently participate in (check all that apply)

- Watching TV
- Place of worship
- Talking in groups
- Outdoors
- On the phone
- Crowded/noisy places
- Concerts
- Business meetings
- Conversations with soft voices
- Lectures
- Exercise activities

Please list the top three situations where you would like to hear better:

1. _____
2. _____
3. _____

Check how often you engage in the following activities:

- Swim underwater Often (>3x/week) Sometimes (1-2x/week) Infrequently
- Scuba dive/skydive Often (>3x/week) Sometimes (1-2x/week) Infrequently

If amplification is deemed necessary, what is most important to you:

(circle number)

	Not important	Somewhat important	Very important		
Invisibility	1	2	3	4	5
Ease of use	1	2	3	4	5
Minimal amount of user maintenance (ie: changing batteries, making repairs)	1	2	3	4	5
Ability to wear in most situations (ie: no need to remove for activities like exercising or telephone use)	1	2	3	4	5