Hearing & Speech Associates, Inc.
12500 Highway 41 N, Suite 6
Evansville, Indiana 47725

Phone: 812 425 1500
Fax: 812 425 0587
evansvillehearing.com

HEARING HEALTH ASSESSMENT

Patient Name _____ Date _____

GENERAL HISTORY
When was your last hearing exam? _____ By Whom? _____
What were the recommendations? _____
When did you start to notice a decline in your hearing (months, years, etc.)?
_____
Have you ever used assistive listening devices? _____ When and what type? _____
Has anyone in your family suffered from hearing loss? _____ Who? _____

MEDICAL HISTORY
Allergies to medications, plastics, etc.?
_____

Current medications
_____

Have you had ear surgery? _____ If yes, which ear? _____ If yes, when? _____

Please list all major surgeries and illnesses (past ten years)
_____

Please select any of the following medical concerns that apply to you:
Diabetes _____ Radiation therapy _____ Compromised immune system _____
Cognitive ability _____ Chemotherapy _____ TMJ _____ Regular MRIs _____

HEARING HISTORY
Please select any of the following hearing concerns or symptoms that apply to you:
Poor hearing _____ Ringing/buzzing _____ Pain/discomfort _____ Drainage _____
Pressure/fullness _____ Recent ear infection _____ Excessive noise exposure _____

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HEARING HEALTH ASSESSMENT

Please select any of the following conditions in which you are experiencing hearing difficulties:
Telephone _____ Television _____ Restaurants _____ Church _____
Background noise _____ Women's/Children's voices _____ Groups _____

Do your hearing difficulties require you to ask for repetition? _____
Do your hearing difficulties limit or hamper your social or personal life? _____
Are your hearing difficulties causing you to hear people but not understand? _____
Are your hearing difficulties causing you to feel as though others are mumbling? _____
Do your hearing difficulties cause you to feel stressed or tired? _____

Please provide the top three listening situations where you are experiencing your greatest hearing difficulties:
Family _____ Religious _____ Meetings _____ Telephone _____ TV _____
Driving _____ Outdoors _____ Travel _____ Restaurant _____ Music _____
Social _____ Other _____

Please provide the top three listening situations where you would like to hear better:
Family _____ Religious _____ Meetings _____ Telephone _____ TV _____
Driving _____ Outdoors _____ Travel _____ Restaurant _____ Music _____
Social _____ Other _____

Please include any additional medical or hearing information you would like us to know below.
_____
_____
_____
_____
_____

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COMPANION QUESTIONNAIRE

Name _____ Patient Name _____

Relationship to Patient _____ Date _____

Please select any of the following conditions in which you feel your friend or loved one is experiencing hearing difficulties:

Telephone _____ Television _____ Restaurants _____ Church _____

Background noise _____ Women's/Children's voices _____ Groups _____

Please mark how often your friend or loved one is experiencing difficulties in the following situations or how often these conditions are affecting his or her lifestyle:

	Frequently	Sometimes	Rarely
Using the telephone	_____	_____	_____
Watching television	_____	_____	_____
Hearing in restaurants	_____	_____	_____
Asking for repetition	_____	_____	_____
He or she feels stressed or tired	_____	_____	_____
He or she hears, but not does not understand	_____	_____	_____

He or she feels that others are mumbling _____ _____ _____