



Associates in Hearing HealthCare, PC

...Hearing Help from the Heart...

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DATE: _____

NAME: _____ AGE: _____ OCCUPATION: _____

WHO REFERRED YOU TO **ASSOCIATES IN HEARING HEALTHCARE**? _____

WERE YOU ASKED TO BRING A FRIEND OR FAMILY MEMBER WITH YOU FOR THIS APPOINTMENT? Y N

WHAT CONCERNS DO YOU HAVE? hearing loss dizziness ear noises
 other, please specify _____

1) WHAT DO YOU WANT TO LEARN FROM YOUR VISIT TODAY? _____

2) IF YOU THINK YOU HAVE A HEARING PROBLEM, PLEASE ANSWER THE FOLLOWING, IF NOT, GO TO #3.

DO YOU HAVE A PROBLEM WITH THE FOLLOWING SITUATIONS? (please check)

While listening to another person at a distance of 6 feet
 In groups and noisy places
 While using the telephone left ear right ear no preference
 At work
 At home
 In social/recreational situations

FROM WHICH EAR DO YOU HEAR BETTER? left ear right ear both same

WHAT DO YOU THINK CAUSED YOUR HEARING LOSS? _____

DID YOUR HEARING LOSS COME ON suddenly gradually

WHEN DID YOU FIRST NOTICE LOSS? _____

HAS IT GOTTEN WORSE OVER TIME? yes no

DOES IT FLUCTUATE FROM TIME TO TIME? yes no

DOES ANYONE IN YOUR FAMILY HAVE A HEARING PROBLEM? yes no
Who? _____

3) HAVE YOU EVER HAD EAR SURGERY? yes no

4) DO YOU HAVE DRAINAGE FROM THE EARS? yes no

5) DO YOU PRESENTLY HAVE "TUBES" IN YOUR EARS? yes no

6) DO YOU HAVE DIABETES? yes no medically stable

7) DO YOU TAKE ANY MEDICATIONS REGULARLY? yes no

If yes, please list: _____

- 8) DO YOU HAVE A COMPROMISED IMMUNE SYSTEM? yes no
- 9) HAVE YOU HAD CHEMOTHERAPY WITHIN THE PAST 6 MONTHS? yes no
- 10) HAVE YOU HAD RADIATION TO THE HEAD OR NECK? yes no
- 11) DO YOU SCUBA/SKYDIVE REGULARLY? yes no
- 12) ARE YOU BOTHERED BY NOISES IN YOUR EARS/HEAD? yes no
 IF YES, right left both
- 13) ARE YOU EVER DIZZY? yes no IF YES, DESCRIBE _____
- 14) HAVE YOU EVER BEEN EXPOSED TO LOUD NOISES FOR ANY LENGTH OF TIME? yes no
 IF YES, DESCRIBE _____
- 15) HAVE YOU EVER USED A HEARING AID IN THE PAST? yes no
- 16) IF YOU ARE USING A HEARING AID NOW, PLEASE ANSWER THE FOLLOWING.
- WHICH EAR IS AIDED? left right both
- HOW LONG HAVE YOU USED AN AID? _____
- HOW LONG HAVE YOU HAD YOUR PRESENT AID? _____
- ARE YOU SATISFIED WITH THE AID? yes no

FOR OFFICE USE ONLY

NOTES:
