HOLLAND
HEARING CENTER

DATE: _______________

NAME: ___________________________ DOB: ___________________

HEARING HISTORY	YES	NO
Is this your first hearing test?		
Have you ever had ear surgery?		
Did you have a history of infections?		
Do you have family history of hearing loss?		
Do you have a history of noise exposure?		
Have you had any head trauma?		
Do you have ringing in your ears?		
If so, does it bother you during the day?		
If so, does it keep you awake at night?		
Have you noticed dizziness?		
If so, is it a spinning sensation?		
If so, is it a light-headed sensation?		
Do you think you have a hearing loss?		
If so, does it make you feel self-conscious?		
If so, does it cause problems with your family?		
If so, does it cause problems at your work?		
Do you have difficulty hearing someone who whispers?		
Do you have difficulty understanding in a group?		
Do you have difficulty understanding the radio or tv?		
Do you ask people to repeat themselves?		
Has anyone mentioned that you may have hearing loss?		
Do you have difficulty understanding in a restaurant?		
Do you have difficulty understanding in worship services?		
Do you have difficulty understanding women & children?		

How long have you noticed hearing loss?

- Less than 1 year
- 1 – 3 years
- 4 – 5 years
- Over 5 years

Why have you decided to have your hearing tested?

- I want to be sure there is no loss
- My family suggested I do this
- I feel my hearing is poor
- I think I need hearing aids
- My employer required it

If we were to find out through the hearing evaluation that you could be helped with hearing instruments, are you ready for that help? YES NO

How does your hearing loss make you feel?

- It doesn't really bother me
- I am really missing out
- There are times it's a problem

MEDICAL HISTORY:

Please list all medications you are currently taking. If you have a list, we would be happy to make a copy:

____

____

It is not unusual to find hearing loss in conjunction with the following health conditions, please indicate all that apply:

___ Smoke cigarettes ___ Diabetes ___ Heart disease ___High blood pressure
___Pacemaker ___ Arthritis ___Depression ____Memory changes ___Low vision

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HEARING AID HISTORY: *Please fill this section out if you have used instruments at some time in the past.*

How many years have you used hearing instruments? __________ Which ear? RIGHT LEFT BOTH

Who was the manufacturer of your instruments? _______________ Were you satisfied with them? YES NO

Are you uneasy wearing hearing instruments? YES NO

Please list situations in which you would like to hear and/or understand better:

____ ____

____ ____

Following is a list of factors to consider when investing in hearing instruments. Please rank these in order of importance to you. Place 1 next to the most important and so on.

____ Understanding speech better ____ Comfort

____ Function in noisy places ____ Cost

____ Cosmetic appearance ____ Batteries