Our concern is your hearing, and to better help you we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs.

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 (MM/DD/YYYY)

**Title:** \_\_\_\_\_\_\_\_\_\_\_ **Name: \_\_\_\_\_\_\_\_\_\_\_\_\_**

(Dr, Mr, Mrs, etc) (Last) (First) (Initial)

**Mailing Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Street)(City) (ST) (Zip)

**Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cellular Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Alternate Contact\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Occupation (past/present) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Local Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**How did you hear about us?**

**Name of spouse/friend with you today?**

**What is your primary reason for today’s visit?**

**MEDICAL/AUDIOLOGIC HISTORY YES NO**

* Will this be the first time you’ve had a hearing test?  

If no, what year were you last tested \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Have you ever had ear surgery?  

If yes, when? \_\_\_\_\_\_\_ Which ear? \_\_\_\_\_\_\_\_\_ Procedure? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you have noises or ringing in your ears?  
* Did you have chronic ear infections as a child or adult?  
* Do you have a family history of hearing loss?  
* Have you been exposed to a lot of noise in your life?  
* Have you had any trauma to the head?  
* Do you have sinus or allergy problems?  

When was your most recent cold, sinus, allergy problem? ­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Do you have any ear pain or pressure**?**  
* Do you have dizziness, vertigo, or loss of balance?  
* In which ear do you hear best? circle: left right
* What do you believe caused your hearing problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you wear hearing aids?  

 If yes, circle: left only right only both ears

What year did you buy your hearing aids? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Approximately how many hours a day do you wear them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any problems with your hearing aids?  

If yes, explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* Why have you decided to have your hearing tested at this time?

 I feel my hearing is poor and may need to be aided.

* Family/friends have suggested I have my hearing checked.
* Other reason/explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

**Have you had or currently have any of the following:**

|  |  |  |
| --- | --- | --- |
| High blood pressure | Heart disease | Stroke |
| Arthritis | Diabetes | Kidney disease |
| Cancer | Mumps | Measles |
| Meningitis | General anesthetic | Pace Maker/Defibrillator  |

**Do you ever use oxygen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Please list any medications that you take:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communications needs, your personal preferences, and your expectation. By having a better understanding of your needs, we can use our expertise to recommend a solution that is most appropriate for you.**

**Please complete the following questions. Be as honest as possible. Be as precise as possible. Thank you.**

1. Please list the top three situations where you would most like to hear better. Be as specific as possible.

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. How important is it for you to hear better?

 **1 2 3 4 5**

 *Not very important Very Important*

1. How motivated are you to wear and use hearing aids?

 **1 2 3 4 5**

 *Not very motivated Very Motivated*

1. How well do you think hearing aids will improve your hearing? I expect them to:

 **1 2 3 4 5**

 *Not be helpful at all Greatly improve my hearing*

1. What is your **most important** consideration regarding hearing aids? Rank the following factors in order of importance, with **1 as the most important** and **4 as the least important**.

Place an **X** on any line that the item has no importance to you at all.

 \_\_\_\_\_ Hearing aid size and the ability of others not to see the hearing aids

 \_\_\_\_\_ Improved ability to hear and understand speech

 \_\_\_\_\_ Improved ability to understand speech in noisy situations (e.g. restaurants, parties)

 \_\_\_\_\_ Cost of the hearing aids

 **AUTHORIZATION FOR RELEASE**

**OF MEDICAL INFORMATION**

We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. **I give my permission for Audiology of NC to obtain and release my medical records so that they can better understand my condition and help me.** This release will be in effect until we receive a written notice from you requesting, we may no longer forward this information.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PATIENT/GUARDIAN’S SIGNATURE DATE**

**ACKNOWLEDGEMENT OF RECEIPT OF**

**NOTICE OF PRIVACY PRACTICES (HIPAA)**

I acknowledge that **I may request a copy** of Audiology of NC’s Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and the website.

* This Notice informs me how Audiology of NC will use my health information for the purposes of my treatment and/or payment for my treatment.
* This Notice explains in more detail how Audiology NC may use and share my health information for other than treatment, payment, and health care operations.
* Audiology of NC will also use and share my health information as required/permitted by law.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRINT NAME of patient or guardian DATE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE of patient or guardian DATE**