BETTER HEARING
REHABILITATION CENTER
BETTER HEARING IS A BETTER LIFE

Better Hearing Rehabilitation Center
Audiologic Services

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Patient Name: _____

1. Chief complaint: __ Hearing Loss (__Right ear/__Left ear/__Both) __Tinnitus/Ringing __Dizziness
   __ Difficulty Hearing (__in Quiet __ in Noise)

2. How long have you noticed this difficulty? _____

3. Do you think your hearing is changing? __Yes (__Gradual __Sudden) __No

4. Have you ever been exposed to loud noise, either recently or in the past? __Yes __No

   If so, please mark all that apply:
   __Farm Machinery __Music __Hunting/Shooting __Factory Noise
   __Power Tools __Military __Jet Engines __Other:

5. Do you have any of the following symptoms? __Deformity of the ear __Drainage of the ear __Sudden or rapid loss within the past 90 days __Acute or chronic dizziness/Imbalance __Ear Pain __Tinnitus/Ringing (Describe the sound(s):_____)

6. Have you ever had your hearing tested? __Yes __No If so, when was your last test? _____

7. Have you ever had surgery that may have affected your hearing? __Yes __No If so, type? _____

8. Who is your primary physician? _____

9. Have you ever had an ear infection? __Yes __No (If so, __as a child __as an adult)

10. Do you take any prescription medications on a regular basis? Please List:

    Medication:_____ For: _____
    Medication:_____ For: _____
    Medication:_____ For: _____

11. Please check any of the following you currently have or have had in the past:

__Arthritis	__Heart Trouble	__Measles	__Parkinson's
__Asthma	__Hepatitis	__Meningitis	__Scarlet Fever
__Bell's Palsy	__High blood pressure	__Mumps	__Sinusitis
__Diabetes	__HIV	__Neurological	__Stroke/TIA
__Head Injury	__Malaria	symptoms	__Visual trouble-sight loss

12. Is there a history of hearing loss in your family? __Yes __No If so, Who? _____

13. Please rank the following in order of importance 1 (most) – 5 (least), if a hearing aid is recommended for you:
    __Improved hearing in quiet __Improved hearing in noise __Cosmetic appearance __Expense
    __Improved hearing on the phone (__Cell __Landline __Both)

14. Type of cell phone: ____ Android _____iPhone _____Do not use cell phone _____Other:

15. If you are currently using a hearing aid, or have in the past, please answer the following:
    Which ear is/was aided? __Right __Left __Both
    How long have you/did you use the aid(s)? _____
    If not currently using, how long has it been since you last used the aid(s)? _____

16. Please list 3 hobbies or interest: _____

HEARING DIFFICULTY QUESTIONNAIRE

Listening Situations	Hearing Quality					Importance to You		
	Poor				Normal	Not	Somewhat	Very
Quiet (One-on-One Conversation)	1	2	3	4	5	1	2	3
Conversation in Noise (or Groups)	1	2	3	4	5	1	2	3
Male Voice	1	2	3	4	5	1	2	3
Female Voice	1	2	3	4	5	1	2	3
Child's Voice	1	2	3	4	5	1	2	3
Church (if applicable)	1	2	3	4	5	1	2	3
Work Place (if applicable)	1	2	3	4	5	1	2	3
Telephone (Cell)	1	2	3	4	5	1	2	3
Telephone (Landline)	1	2	3	4	5	1	2	3
Television	1	2	3	4	5	1	2	3
Other (Please specify)	1	2	3	4	5	1	2	3