sonus hearing care professionals

Date

Patient Hearing Health Interview

Patient Name _____ DOB _____

Companion Name _____

1. Tell me what prompted you to visit today? _____

2. What do you hope to achieve from your visit today? _____

3. What have you noticed about you hearing/communication ability? _____

_____

4. How long have you noticed any difficulties? _____

5. What are the people closest to you saying about your hearing/communication ability? _____

_____

6. Have you had your hearing tested before? If so, by whom? _____ Date: _____

7. Check any of the following conditions, and add any comments that may help us understand and treat all hearing concerns.

Pain/Discomfort in ears _____

Noise/Ringing in ears _____

History of hearing loss in family _____

Dizziness or balance problems (acute or chronic) _____

Excessive noise exposure _____

Surgery or medical problems with ears,
active drainage within previous 90 days _____

Sudden hearing loss in past 90 days
(unilateral or rapidly progressive within previous 90 days) _____

Visible congenital or traumatic deformity of the ear _____

Audiometric air-bone gaps equal to or greater than 15dB _____

Visible evidence of significant cerumen accumulation or foreign body in the ear canal _____

8. Diabetes? _____ Taking medication? _____

9. High Blood Pressure? _____ Taking medications? _____

9. Do you have any other medical condition that we should be aware of? _____

_____

10. Who is your family physician? Doctors Name: _____