Hear USA

Hearing Health Profile

Existing Patients

Welcome back to HearUSA! We appreciate your ongoing trust in our services.

Please take a few moments to update your information and share any changes since your last hearing test at HearUSA. Your feedback is invaluable in helping us continue to provide personalized hearing care.

Name _____ DOB ____/____/____

What brings you in to have your hearing tested today? _____

_____

Who is attending with you today? _____

Have you experienced a change in hearing since your last hearing test? ☐ Yes ☐ No ☐ Not Sure

Do you experience noises (ringing, buzzing, etc.) in your ears (tinnitus)? ☐ Yes ☐ No _____

Do you have pain or discomfort or discharge in your ears? ☐ Yes ☐ No _____

Have you had ear surgery or other medical problems in your ears? ☐ Yes ☐ No _____

Have you had any dizziness or difficulties with your balance in the last 90 days? ☐ Yes ☐ No _____

Please list any medications or current medical conditions for which you are currently being treated for:

_____ _____ _____

_____ _____ _____

Do your friends and family suggest that your hearing has changed? ☐ Yes ☐ No _____

Is there a history of hearing loss in your family? ☐ Yes ☐ No _____

Have you ever experienced loud noise for an extended period of time? ☐ Yes ☐ No _____

If yes, where? _____

Do you currently wear hearing aids? ☐ Yes ☐ No _____

If yes, describe your experience with current hearing aids ☐ Satisfied ☐ Dissatisfied ☐ Undecided

Do you have any limitations with the following:

Vision (seeing small items in front of you) ☐ Yes ☐ No _____

Dexterity (picking up small items, numbness in fingers) ☐ Yes ☐ No _____

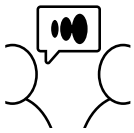
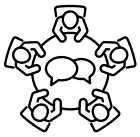
_____ _____

Signature Date

Communication Questionnaire

Name _____ DOB ____/____/____

Please check the box for each area where you have hearing difficulties. Be sure to consider all aspects of your lifestyle. If you wear hearing aids please answer based on your experience wearing them.

☐  One on One Conversations	☐  Small Group Conversation	☐  TV/Movies	☐  Music/Radio	☐  Telephone
☐  In the Car	☐  Outdoor	☐  Theater/Worship	☐  Family Gatherings/ Meetings	☐  Restaurants/Parties

What situations are important for you to hear better:

1. _____
2. _____
3. _____

How often do you withdraw from conversations? ☐ Frequently ☐ Occasionally ☐ Rarely/Never

How often do you feel frustrated trying to listen? ☐ Frequently ☐ Occasionally ☐ Rarely/Never

How often do you avoid places because you cannot hear well? ☐ Frequently ☐ Occasionally ☐ Rarely/Never

How often do you ask others to repeat? ☐ Frequently ☐ Occasionally ☐ Rarely/Never

If you use a SMART (cell) phone, what type of phone? ☐ iPhone ☐ Android ☐ Not Sure

Do you use apps on your Smartphone? ☐ Yes ☐ No

If new hearing aids are recommended, are you ready to move forward today?

☐ Yes ☐ No ☐ Maybe

Below is a list of additional considerations regarding hearing instruments. Please check items most important to you:

☐ Ease of Use ☐ Follow-up Care/ Maintenance ☐ Comfort ☐ Overall Sound Quality ☐ Style and Appearance ☐ Cost

_____ _____

Signature Date