ADULT HEARING HEALTH PROFILE

Name: _____ **Date:** _____

1. Have you had your hearing tested before? ☐ Yes ☐ No If yes, where? _____
2. Do you have loss of hearing in one or both ears? ☐ Right Ear ☐ Left Ear ☐ Both
3. How long have you noticed hearing loss? ☐ 5 years/more ☐ Less than 1 year ☐ Over 1 year ☐ Less than 90 days
4. Do you have pain or discomfort in your ears? ☐ Yes ☐ No ☐ Right ear ☐ Left Ear Duration: _____
5. Have you had any surgeries or medical problems with your ears? Any drainage from your ears? ☐ Yes ☐ No _____
6. Do you have any noises or ringing in your ears? ☐ Yes ☐ No _____
7. Have you had any recent **(within 90 days)** dizziness or difficulties with your balance? ☐ Yes ☐ No _____
8. Is there a history of hearing loss in your family? ☐ Yes ☐ No _____
9. Have you been exposed to loud noise for extended periods of time? ☐ Yes ☐ No _____
10. Please list any previous or current medical conditions for which you are being treated: _____
11. Please list medications: _____
12. Have hearing aids been recommended to you or are you currently using hearing aids? ☐ Yes ☐ No _____
13. What type of hearing aids are you using? Right Ear: _____ Left Ear: _____
14. Do you use your hearing aids several hours each day? ☐ Yes ☐ No (If no, why not?) _____
15. Describe your experience with current hearing aids: ☐ Satisfied ☐ Dissatisfied ☐ Undecided

16. Comments or questions: _____

Patient Signature: _____

FOR INTERNAL USE ONLY

Otoscopy: ☐ **Clear** **Cerumen:** ☐ **Right** ☐ **Left**

Diagnosis and Findings: (Identify previous diagnoses)

Auricular Defect : ☐ **None** ☐ **Right** ☐ **Left**

Patient Specific Needs/PD Details: _____

(Prioritize 3 main listening environments from SAC & Cosmetic, tech, cost))

Recommendation:

Outcome: ☐ **Pursue Recommendation** ☐ **Will Consider Recommendation** ☐ **Will not pursue recommendation due to:** _____

Provider Signature: _____ **Date:** _____

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