Hearing Health Assessment
Current Hearing Technology Users

SOUTHSOUND AUDIOLOGY

Patient Name: ______________________________ Date: ____________

General History

When was your last hearing exam? ______________________ By whom? ____________

What were the recommendations? ______________________________

How long ago did you start to notice a decline in your hearing?

☐ Within past 90 days ☐ 1–3 years ☐ 4–6 years ☐ 7–10 years ☐ 10+ years

Do you suffer from acute or chronic dizziness? ☐ Yes ☐ No

Has anyone in your family suffered hearing loss? ☐ Yes ☐ No If yes, who? ____________

Medical History

☐ Diabetes ☐ Radiation therapy to local area ☐ Compromised immune system

☐ Cognitive ability ☐ Chemotherapy within 6 months ☐ TMJ

Allergies to any medications, plastics, etc.? ______________________________

Current medications ______________________________

Have you ever had ear surgery? ☐ Yes ☐ No If yes, which ear? ☐ Right ☐ Left

Type ______________________________

Do you have regular MRIs? ☐ Yes ☐ No

Please list all major surgeries and illnesses (past 10 years) ______________________________

____

		Right Ear	**Left Ear**
INTERVIEW	Patient Experience	☐ Poor hearing ☐ Telephone ☐ Ringing ☐ Pain/discomfort ☐ Drainage (past 90 days) ☐ Excessive noise exposure	☐ Poor hearing ☐ Telephone ☐ Ringing ☐ Pain/discomfort ☐ Drainage (past 90 days) ☐ Excessive noise exposure
EXAMINATION	Audiometric Range	☐ Within range ☐ Out of range	☐ Within range ☐ Out of range
	Middle Ear & Outer Ear	☐ TM perforation ☐ PE tube ☐ Osteoma ☐ Cholesteatoma ☐ Malformation ☐ Exostosis ☐ Cerumen buildup ☐ Keratosis obturans ☐ Chronic or acute drainage	☐ TM perforation ☐ PE tube ☐ Osteoma ☐ Cholesteatoma ☐ Malformation ☐ Exostosis ☐ Cerumen buildup ☐ Keratosis obturans ☐ Chronic or acute drainage
	Skin Condition	☐ Contact dermatitis ☐ Chronic external otitis ☐ Thin, dry skin; risk of trauma	☐ Contact dermatitis ☐ Chronic external otitis ☐ Thin, dry skin; risk of trauma
	Ear Geometry	☐ Too narrow ☐ Vertical step ☐ Ant/post bulge ☐ V-shaped	☐ Too narrow ☐ Vertical step ☐ Ant/post bulge ☐ V-shaped

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Current hearing technology

Brand and model of your hearing technology ______________________________

Style of technology ☐ Behind-the-Ear ☐ In-the-Ear (describe)

Do you wear technology in both ears? ☐ Yes ☐ No

How many years ago did you purchase your technology? ☐ 1–3 ☐ 3–5 ☐ 5+

My current hearing technology...

	Yes	No
Feels comfortable	☐	☐
Emits feedback or whistling noises	☐	☐
Provides hearing confidence on a day-to-day basis	☐	☐
Is cosmetically appealing	☐	☐

How often is your hearing technology's performance meeting your listening lifestyle needs?

	Frequently	Sometimes	Rarely
On the phone	☐	☐	☐
While watching TV	☐	☐	☐
In a restaurant	☐	☐	☐
In social or personal life	☐	☐	☐
In conversations with spouse or family	☐	☐	☐
In background noise	☐	☐	☐

	Frequently	Sometimes	Rarely
In conversations with women or children	☐	☐	☐
In understanding what others are saying	☐	☐	☐
In reducing the feeling that people are mumbling	☐	☐	☐
In reducing the feeling of being stressed or tired after listening for long periods of time	☐	☐	☐

Please provide the top three listening situations where you would like to hear better.

1. ______________________________
2. ______________________________
3. ______________________________

Please select your current lifestyle and your desired lifestyle.

Active Lifestyle (Frequent Background Noise)

☐ Current ☐ Desired

Casual Lifestyle (Occasional Background Noise)

☐ Current ☐ Desired

Quiet Lifestyle (Limited Background Noise)

☐ Current ☐ Desired

Very Quiet Lifestyle (Rare Background Noise)

☐ Current ☐ Desired

Notes: ______________________________