WHC
WORTH HEARING CENTER

RETURNING PATIENT HEARING HEALTH ASSESSMENT

NAME: _____ DOB: _____

(Clinic Use Only) Pt. ID# :_____

REASON FOR TODAYS VISIT: _____

(CHECK ALL CONDITIONS THAT APPLY)

- ☐ DIZZINESS: _____
- ☐ EAR DRAINAGE: _____
- ☐ EAR PAIN: _____
- ☐ EAR INFECTIONS: _____
- ☐ NOISE EXPOSURE: _____
- ☐ EAR SURGERIES:_____
- ☐ TINNITUS/EAR NOISES (RINGING, BUZZING, HUMMING): _____
- ☐ HISTORY OF FALLING: _____

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING CONDITIONS?
(CHECK ALL THAT APPLY)

☐ DIABETES ☐ DEMENTIA ☐ CANCER ☐ STROKE

☐ HEAD TRAUMA ☐ VISION PROBLEMS ☐ HIGH BLOOD PRESSURE

☐ HEAD/NECK PROBLEMS ☐ THYROID DISEASE ☐ TMJ DISORDER ☐ HEART DISEASE

☐ DEPRESSION ☐ ANXIETY ☐ ALLERGIES ☐ MENINGITIS ☐ TOBACCO USE

Please list current medications:

_____

_____

_____

_____

AUDIOLOGIC HISTORY
Please fill this out only if you have a hearing loss or suspicion of hearing loss

DO YOU FEEL HAVE HAD A CHANGE IN YOUR HEARING? : _____

DATE/LOCATION OF LAST HEARING TEST: _____
(Only fill out if your test was **NOT** done at Worth Hearing Center)

CURRENT HEARING AID USER?:_____ PLEASE FILL OUT THE CORRESPONDING

COMMUNICATION ASSESSMENT:

DOES A HEARING LOSS A=Always S=Sometimes N=Never

Cause you to feel embarrassed or uncomfortable meeting new people?	A	S	N
Cause you to feel frustrated when talking to family members?	A	S	N
Make it difficult for you to converse on the telephone?	A	S	N
Cause difficulty following conversations in a restaurant?	A	S	N
Cause you to ask people to repeat themselves?	A	S	N
Cause you to have difficulty hearing in background noise?	A	S	N
Cause you to feel as though others mumble?	A	S	N
Cause you to attend religious or social functions less than you would like?	A	S	N
Cause you to have arguments with family or friends?	A	S	N
Cause you to feel stressed or tired when listening for long periods of time?	A	S	N
Cause others to complain that you turn up the television or radio too loud?	A	S	N
Limit or hamper your social life?	A	S	N
Allow you to hear people speak but fail to understand what they say?	A	S	N

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

1. _____
2. _____
3. _____

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(Clinic Use Only) **PROVIDER: _____**

DATE: _____