Hearing Evaluation Services of Buffalo, Inc.
It's Good to Hear

Insurance Questions?
Call our Insurance Specialist
544-6210

Adult Hearing Health History

Name: _____ Date of Birth: _____ Gender: M F

Primary Care Physician: _____Current/Former Occupation: _____

What is the reason for your visit (primary concern)? _____

How did you hear about us: ☐ Television ☐ Radio ☐ Phone Book ☐ Internet (Search Engine)
☐ Internet (Social Media) ☐ Mailer ☐ Family/Friend ☐ Physician ☐ Other: _____

Hearing History: If you answer YES to any questions, please explain further.

Yes No Do you feel you have a hearing loss? Is one ear worse? Right Left No Difference

Has your hearing loss occurred gradually or very suddenly? Gradual Sudden

Approximately when did you first notice your hearing loss? _____

Yes No Have you ever had your hearing tested? When, where, & results: _____

_____

Yes No Have you ever worked in a loud place or participated in loud activities? Explain: _____

_____

Yes No Do/did you consistently use hearing protection at work or during these loud activities?

Yes No Do you hear ringing or buzzing in your ears (tinnitus)? If yes, when did it start? _____

Which ear(s): Right Left Both Does it bother you? Yes No

Is the tinnitus constant or occasional? Constant Occasional

Yes No Does anyone else in your family have difficulty hearing? Who? _____

Medical History: If you answer YES to any questions, please explain further.

Yes No Do you have a history of ear infections or ear surgery?
Explain: _____

Yes No Have you ever seen a doctor for an ear-related issue?
Name of doctor, date and reason for visit: _____

Yes No Pain in your ears? Which ear(s): Right Left Both

Yes No Drainage from your ears (that is not wax)? Which ear(s): Right Left Both

Yes No Dizziness? Is it: Constant Occasional

Yes No Imbalance? Is it: Constant Occasional

Yes No Do you have any allergies (ex. Latex, Acrylic, dyes)? _____

Yes No Have you ever had chemotherapy or radiation? _____

Yes No Have you ever had IV antibiotics? _____

Yes No Do you currently reside with someone? Who? _____

Yes No Have you used a tobacco product (cigarette, cigar, smokeless tobacco) at all in the past 24 months? What type(s) of products and how often? _____

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Do you have any of the following medical conditions? Please check all that apply and include the name and specialty of the managing physician (i.e. Dr. Laura Smith, Endocrinologist)

Condition	Condition
☐ Anemia	☐ Thyroid Disease
☐ Dementia	☐ Rheumatoid Arthritis
☐ Depression	☐ Fibromyalgia
☐ Diabetes	☐ Psoriasis
☐ High Cholesterol	☐ Sleep Apnea
☐ High Blood Pressure	☐ Kidney Disease

Please list all your medications, vitamins, etc **(If you have this written down, we will copy it for you)**

Name *(please write legibly)*	Dosage	Frequency	Route (mouth, spray, etc.)	Reason

Your Hearing Needs:

What is your hearing aid experience? ☐ I have a hearing aid and use it regularly

☐ I have never used a hearing aid. ☐ I have tried a hearing aid but returned it/don't use it

Please list the top 2 situations where you would most like to hear better. Be as specific as possible.

1. _____

2. _____

On a scale of 1 to 10, how ready are you to get help for your hearing difficulty?

Not At All Ready 1 2 3 4 5 6 7 8 9 10 **Very Ready**

Signature: _____ **Date:** _____

Please bring this completed form to your appointment.

Reviewed by & Date: _____ Revised 3/2/23