Appalachian Hearing and Speech Center

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Confidential Patient History Page 2 - Dated:_____

Patient Name _____ **Birth Date:** _____

Address: _____

City: _____ **State:** **Zip Code:** _____

ABOUT YOUR HEARING: Do you experience difficulty with the following?

Yes No Understanding conversation
Yes No Hearing in a crowd
Yes No Hearing by telephone
How long have you had a hearing problem? _____
Yes No Does anyone else in your family have a hearing problem?
What relationship? _____
Yes No Do you now or have you ever worn a hearing aid?
Yes No If yes, did the hearing aid help you?
How old are your hearing aids?_____
Yes No Does your hearing bother you or those around you?
Yes No Has someone told you that you do not hear well?
Yes No Do people have to repeat things for you?
If yes, must they repeat things: Seldom Frequently
Yes No Do you lip read or feel you must see the person's lips to understand what they say?
Yes No Do you need the television louder than other family members?
Yes No If it is possible, are you interested and would you accept help with your hearing aids?

NOISE EXPOSURE:

What is or what has been your occupation: _____
Yes No Have you ever had workplace noise exposure?
If yes explain. _____
Yes No Do you have noisy hobbies?
Yes No Do you: Shoot guns?
Yes No Operate noisy equipment (power tools, farm equipment, etc)
List any other loud noise sources: _____
Yes No Do you wear hearing protection (ear plugs or muffs)?
Yes No Have you always worn hearing protection?

Signature _____ Date _____