Name:____ Date:________________

What motivated you to come in today?____

____

Have you experienced or been diagnosed with any of the following? Please circle all that apply.

Ear Drainage	Yes	No	Ear(s): Right	Left	Both
Ear Pain	Yes	No	Ear(s): Right	Left	Both
Ear Surgery	Yes	No	Ear(s): Right	Left	Both
Ringing/Noises in Your Ears	Yes	No	Ear(s): Right	Left	Both

Arthritis	Yes	No
Cancer	Yes	No
Depression/Anxiety	Yes	No
Dementia/Alzheimer's Disease	Yes	No
Diabetes	Yes	No
Dizziness or Unsteadiness	Yes	No
Family History of Hearing Loss	Yes	No
Hypertension	Yes	No
Macular Degeneration	Yes	No
Noise Exposure	Yes	No

Have you had your hearing tested before? Yes No If Yes please list date_________________

What is your experience with hearing devices?

_____ I have a hearing device(s) and use it regularly on the _____Right _____Left _____Both ears

_____ I have had a trial with hearing device(s)

_____ I have inquired about hearing device(s) in the past

_____ I have never used hearing device(s)

Please rate your motivation in pursing treatment for your hearing needs (1=low and 10=very high)

1 2 3 4 5 6 7 8 9 10

Please mark the following areas where you feel you would like to improve your hearing:

_____Quiet Situations _____Restaurants/Social Gatherings _____Phone

_____Television _____Meetings/Lectures _____Workplace

_____Outdoors activities _____Church/Place of Worship _____Car

If a hearing device(s) is a viable treatment plan to improve your hearing what options are most important to you when considering a device. Please mark your top 3 choices.

_____Appearance _____Automatic Capabilities _____Sound Quality/Clarity

_____Durability _____Price _____Bluetooth/Wireless Connectivity

_____Rechargeable Batteries