HEALTHCARE QUESTIONNAIRE

NAME_____ Home PHONE_____
Cell PHONE _____
Other PHONE_____
ADDRESS_____

CITY_____ STATE ____ ZIP_____ E-MAIL_____

DATE OF BIRTH_____ SPOUSE'S NAME_____

FAMILY PHYSICIAN_____ May we send results to? yes____no___
INSURANCE CARRIER (if applicable)_____ ID_____
What prompted you to come in today? _____
How did you hear about us? _____

SUBJECTIVE HEARING ASSESSMENT AND HISTORY

Approximate date of your last hearing test _____
Do you wear hearing aids? _____ Which ear? _____
Are you having problems with your hearing aids? _____
Describe the problem_____

Do you have difficulties understanding in noise or groups? yes_____no_____
Do family members or friends say your TV is too loud? yes_____no_____
Do you ask people to repeat themselves? yes_____no_____
Do you hear people speaking but have trouble understanding the words? yes_____no_____
Do you hear some people better than others? yes_____no_____
Do you have any difficulty hearing in the car? yes_____no_____
Have you ever avoided a situation because of your hearing problem? yes_____no_____
Must others raise their voices or move closer to help you hear them? yes_____no_____
Do you ever have to concentrate so much to listen that you tire from it? yes_____no_____
Do you have a better ear? If yes, which ear? _____ yes_____no_____
Do you have ringing or noise in your ears? yes_____no_____
Do you wear a pacemaker? yes_____no_____
Do you take blood thinning medication? yes_____no_____
In what specific situations would you like to hear better? _____

DATE: