Audiology
Of Greenville, New Bern, and Wilmington

BETTER HEARING QUESTIONNAIRE

Our concern is your hearing, and to better help you we ask that you fill out this questionnaire to describe in what ways your hearing affects you. This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs.

Date: _____ **Age:** _____ **Date of Birth:** _____ (MM/DD/YYYY)

Name: _____ (Last) (First) (Initial)

Mailing Address _____ (Street) (City) (ST) (Zip)

Home Phone _____ **Cellular Phone** _____ **EMAIL** _____

Occupation (past/present) _____ **Local Doctor:** _____

Health Insurance/Health Plan: _____

How did you hear about us? _____
Name of spouse/friend with you today? _____
What is your primary reason for today's visit? _____

MEDICAL/AUDIOLOGIC HISTORY

	YES	NO
▪ Will this be the first time you've had a hearing test?	☐	☐
If no, what year were you last tested _____		
▪ Have you ever had ear surgery?	☐	☐
If yes, when? _____ Which ear? _____ Procedure? _____		
▪ Do you have noises or ringing in your ears?	☐	☐
▪ Did you have chronic ear infections as a child or adult?	☐	☐
▪ Do you have a family history of hearing loss?	☐	☐
▪ Have you been exposed to a lot of noise in your life?	☐	☐
▪ Have you had any trauma to the head?	☐	☐
▪ Do you have sinus or allergy problems?	☐	☐
When was your most recent cold, sinus, allergy problem? _____		
▪ Do you have any ear pain or pressure**?**	☐	☐
▪ Do you have dizziness, vertigo, or loss of balance?	☐	☐
▪ In which ear do you hear best? circle:	left	right
▪ What do you believe caused your hearing problem? _____		
▪ Do you wear hearing aids?	☐	☐
If yes, circle:	left only	right only both ears
What year did you buy your hearing aids? _____		
Approximately how many hours a day do you wear them? _____		
Do you have any problems with your hearing aids?	☐	☐
If yes, explain: _____		

▪ Why have you decided to have your hearing tested at this time?
- ☐ I feel my hearing is poor and may need to be aided.
- ❒ Family/friends have suggested I have my hearing checked.
- ❒ Other reason/explain: _____

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Wilmington, NC 28405

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MEDICAL HISTORY

Have you had or currently have any of the following:

High blood pressure	Heart disease	Stroke
Arthritis	Diabetes	Kidney disease
Cancer	Mumps	Measles
Meningitis	General anesthetic	Pace Maker/Defibrillator

Please list any medications that you take: _____

_____

Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communications needs, your personal preferences, and your expectation. By having a better understanding of your needs, we can use our expertise to recommend a solution that is most appropriate for you.

Please complete the following questions. Be as honest as possible. Be as precise as possible. Thank you.

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

   _____

   _____

   _____

2. How important is it for you to hear better?

   1 **2** **3** **4** **5**
   Not very important *Very Important*

3. How motivated are you to wear and use hearing aids?

   1 **2** **3** **4** **5**
   Not very motivated *Very Motivated*

4. How well do you think hearing aids will improve your hearing? I expect them to:

   1 **2** **3** **4** **5**
   Not be helpful at all *Greatly improve my hearing*

5. What is your **most important** consideration regarding hearing aids? Rank the following factors in order of importance, with **1 as the most important** and **4 as the least important**.
   Place an **X** on any line that the item has no importance to you at all.

   _____ Hearing aid size and the ability of others not to see the hearing aids
   _____ Improved ability to hear and understand speech
   _____ Improved ability to understand speech in noisy situations (e.g. restaurants, parties)
   _____ Cost of the hearing aids