Cleartone Hearing Aid Services
and
Medina Hearing Aid Services

HEARING HEALTH INTERVIEW

Name:_____ Date:_____

1. What is the reason for your upcoming visit?_____
2. How would you rate your hearing?_____
3. What bothers you the most about your hearing?_____
4. What do you believe caused your hearing problem?_____
5. How long have you noticed any difficulties?_____
6. What have others noticed about your hearing/communication ability?_____

_____

7. In what situations is it necessary for people to repeat themselves?_____
8. Explain any problems you have using the telephone._____
9. Do you listen to the television louder than your family/friends would like?_____
10. How does background noise interfere with your ability to understand conversation?_____

_____

11. What one person do you have the most difficulty hearing?_____
12. Are there any activities you avoid or have stopped because of your hearing?_____
13. How much difficulty do you have understanding in groups?_____
14. Describe a time you had difficulty understanding conversation in a group setting._____

_____

15. If we find that we could help improve your hearing, are you ready to proceed with amplification?_____

16. Have you ever worn hearing aids?_____ If yes, what type of aids? _____

If you could improve two or three things about your current hearing aids, what would they be?

_____

_____

If no, do you know anyone with hearing aids?_____ How satisfied is this person with the aids?_____

_____

17. Please check any of the following conditions that you have and add any comments:

YES	NO	
☐	☐	Pain/discomfort in ears :_____
☐	☐	Noises in the ears:_____
☐	☐	History of hearing loss in the family:_____
☐	☐	Dizziness or balance problems:_____
☐	☐	Excessive noise exposure:_____
☐	☐	Surgery or medical problems with ears/drainage:_____
☐	☐	Sudden hearing loss in the past 90 days:_____
☐	☐	(Clinician response only) Air/Bone gap greater than 15 dB at .5, 1, 2 KHz _____

18. Do you now or have you ever worked in a noisy place, or participated in any loud hobbies or activities?

If yes, length of exposure:_____

Last exposure:_____

Was ear protection worn?_____

19. Do you have any other medical conditions of which we should be aware?_____

_____

20. What medications are you presently taking?_____

_____

Comments:_____

_____