Hearing Health Report

HEARING CENTERS OF NEVADA

About You

Patient Name:_____ Today's Date:_____

Date of Birth:_____ ❑ Male ❑ Female

Address:_____ City:_____ St:_____ Zip:_____

Phone:( ) – _____ ❑ Home ❑ Cell ❑ Alternative

Email:_____ Occupation:_____ ❑ Past ❑ Present

Marital Status: ❑ Single ❑ Married ❑ Widowed Spouse's name:_____

Name of Physician:_____ Location:_____

Permission to release test information to your physician: ❑ Yes ❑ No _____ *Signature*

Primary Health Ins:_____ Policy (ID#):_____ Group#:_____

Secondary Health Ins:_____ Policy (ID#):_____ Group#:_____

How did you hear about us? ❑ Mail ❑ Phone ❑ Newspaper ❑ Yellow Pages ❑ Website
❑ Television ❑ Sign ❑ Other_____

If you were referred to us, who may we thank?:_____

Your Hearing Health History

Allergies:_____ Are you an insulin-dependent diabetic?_____

Please list any medications you are currently taking:_____

Do you have ringing in your ears?: ❑ Right Ear ❑ Left Ear For how long?_____

Have you previously had a hearing test? ❑ Yes ❑ No If so, when?_____

Have you received any medical or surgical treatment for a hearing loss?_____

If Yes, when?_____ Physician/ENT:_____

Additional information about treatment:_____

Any history of, or active drainage from the ear within the previous 90 days? ❑ Yes ❑ No

Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ❑ Yes ❑ No

Have you experienced any acute or chronic dizziness?: ❑ Yes ❑ No

Have you experienced any pain or discomfort?: ❑ Right Ear ❑ Left Ear

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Any visible congenital or traumatic deformity of the ear?_____

Visible evidence of significant cerumen accumulation or a foreign body in the ear canal?_____

Audiometric air-bone gap equal to, or greater than, 15 dB at 500 Hz, 1000 Hz and 2000 Hz? ❑ Yes ❑ No

Hearing Acuity Assessment

Name:_____ Phone:_____ Date:_____

PLEASE ANSWER THE FOLLOWING QUESTIONS BY CHECKING THE APPROPRIATE RESPONSE:	Yes	Sometimes	No
1. Have you observed that a hearing problem causes you to have difficulty understanding in group situations?	Ⓨ	Ⓢ	Ⓝ
2. Have you observed that a hearing problem causes you to ask people to repeat what they have said?	Ⓨ	Ⓢ	Ⓝ
3. Have you noticed difficulty hearing when someone speaks in a whisper?*	Ⓨ	Ⓢ	Ⓝ
4. Have you observed that a hearing problem causes you to ask people to speak louder or move closer?	Ⓨ	Ⓢ	Ⓝ
5. Have you noticed that a hearing problem causes you difficulty when listening to the TV or radio?*	Ⓨ	Ⓢ	Ⓝ
6. Have you observed that a hearing problem causes you difficulty when visiting friends, relatives or neighbors?*	Ⓨ	Ⓢ	Ⓝ
7. Do you think that a hearing problem causes you to avoid situations or activities more often than you would like?	Ⓨ	Ⓢ	Ⓝ
8. Have you noticed that a hearing problem causes you to have difficulty on the telephone?	Ⓨ	Ⓢ	Ⓝ
9. Are you concerned that any difficulty with your hearing limits or hampers your personal or social life?*	Ⓨ	Ⓢ	Ⓝ
10. Have you observed that a hearing problem causes you difficulty when in a restaurant with relatives or friends?*	Ⓨ	Ⓢ	Ⓝ

SCORING

Score _____

"Yes" Response: 2 points	"Sometimes" Response: 1 point	"No" Response: 0 points

0-3 points	No perceived impairment	**8-11 points**	Moderate perceived impairment
4-7 points	Mild perceived impairment	**12-20 points**	Severe perceived impairment

*Adapted from HHIE

Notice of Privacy Practices

We are committed to our patients right to privacy. All information regarding your condition, diagnosis or treatment is strictly confidential and will only be release with your written consent to your privacy care physician, family, friends, employers, attorneys or insurance companies.

By my signature below, I hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I have read, understand and I have had an opportunity to ask questions about the use and disclosure of my protected health information, and other concerns regarding my protected health information.

Signature of Patient (or patients representative):_____ Date: _____

Legal authority of representative:_____

Hearing Care Professional:_____ Lic. #:_____

Office Location:_____