

# 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. Please complete both pages and return to the front desk.

**Name:** .....  
(Last) (First) (Initial)

**Date:** ..... **Date of Birth:** .....  
(M/D/Y)

**Mailing Address:** .....  
(City) (State) (Zip)

**Local Telephone #:** ..... **Cell Phone #:** .....

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

**Hearing Aid Insurance/Health Plan:** ..... **Policy #:** .....

**How did you hear about us?** .....

**Your e-mail address:** .....

**Name of spouse/family member/friend with you today:** .....

**Relationship to you:** .....

**Marital Status:** Single Married Divorced Widow(er) **Student:** No Full Time Part Time **Work:** No Full Time P/T

**Do you have a PACE MAKER? YES / NO**



8515 Spring Cypress Rd, Ste 105, Spring, Texas 77379  
281-444-9800 281-257-1594 (Fax)  
[www.NorthHoustonHearing.com](http://www.NorthHoustonHearing.com)

## Medical/Audiologic History

Have you had or currently have any of the following (check all that apply):

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 your ear canals itch?		
Do you have sinus or allergy problems?		
Do you have difficulty hearing when someone speaks in a whisper?		
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?		
Does a hearing problem cause you to attend church less often than you would like?		
Does a hearing problem cause you difficulty when listening to TV or radio?		
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?		
Do you have difficulty hearing women or children?		
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:		
What do you believe caused your hearing problem?		
In which ear do you hear better? circle: left right		

## Medical History

Have you had or currently have any of the following (check all that apply):

High Blood Pressure	Heart Disease	Stroke
Arthritis	Diabetes	Kidney Disease
Cancer	Mumps	Measles
Meningitis	General Anesthetic	



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## Hearing Difficulty Questionnaire

Indicate your ability to hear (Hearing Quality) in the following listening situations and rate the importance of that listening situation to you. Circle the appropriate number in columns two and three.

LISTENING SITUATION	HEARING QUALITY					IMPORTANCE TO YOU		
	POOR		NORMAL		NOT	SOMEWHAT	VERY	
QUIET (one on one conversation)	1	2	3	<b>4</b>	5	1	2	3
TELEVISION	1	2	3	<b>4</b>	5	1	2	3
RESTAURANTS	1	2	3	<b>4</b>	5	1	2	3
CHURCH	1	2	3	<b>4</b>	5	1	2	3
MEETING/GROUPS	1	2	3	<b>4</b>	5	1	2	3
WORK PLACE	1	2	3	<b>4</b>	5	1	2	3
TELEPHONE	1	2	3	<b>4</b>	5	1	2	3
CAR	1	2	3	<b>4</b>	5	1	2	3
MALE VOICE	1	2	3	<b>4</b>	5	1	2	3
FEMALE VOICE	1	2	3	<b>4</b>	5	1	2	3
CHILD'S VOICE	1	2	3	<b>4</b>	5	1	2	3
OTHER (please explain below)	1	2	3	<b>4</b>	5	1	2	3

### Assessment Of Priorities Relating To Hearing Correction

Following you will find a list of important factors to consider when purchasing a hearing instrument. Please rate them in order of importance from 1 to 6 by placing the number 1 next to the most important factor, the number 2 next to the second most important factor, and so on through number 6, which is the least important factor to you.

- |                                   |                                     |               |
|-----------------------------------|-------------------------------------|---------------|
| ..... Understanding speech better | ..... Function in noisy environment | ..... Cost    |
| ..... Inconspicuous Appearance    | ..... Comfort                       | ..... Service |

**I have received a copy of the Notice of Privacy Practices.**

..... **Date** .....

(Patient's Signature)



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