



Hearing Health Assessment

TO BE COMPLETED BY PATIENT

Patient Name _____ Sex M F DOB ____/____/____
First Last MI MM DD YYYY

THIS PORTION TO BE COMPLETED BY HEARING CARE PROFESSIONAL

- Quiet Conversation
- Door Bell
- Phone Ringing
- Alarms
(Clock, Security, Timers, etc.)

- Home Telephone
- Driving
- Religious Services
- Adult Conversations
- Small Family Gatherings
- Quiet Restaurants

- Cell Phones
- Shopping
- Movie Theaters
- Health Clubs
- Small Group Meetings
- Conversations with Children
- Television
- Open/Reverberant Home
- iPod®/Personal Music Players
- Moderately Noisy Restaurants

- Outdoor Activities
- Entertainment Venues
(Casinos, Exhibit Halls, etc.)
- Busy Restaurants
- Frequent Social Gatherings
- Smart Phones
- Conference Calls
- Multimedia Connectivity
(Home Theater, Computer, Phone, etc.)
- Travel & Airports
- Concerts & Arts
- Group Presentations

Total _____

Total x2 _____

Total x3 _____

Total x4 _____ Grand Total _____

Desired lifestyle? Private Quiet Active Dynamic Does the companion agree? Yes No

What are the top 3 environments you would like to hear better in? SCALE OF 1-4 PRE POST

1. _____
2. _____
3. _____

OTHER COMMENTS:

OFFICE USE ONLY:

Tubing Length _____ BTE Color _____ Pacemaker _____