



Name: _____
Date: _____ **DOB:** _____ **Age:** _____ **Sex:** _____
Address: _____

Home Phone: _____ **Secondary Phone:** _____
Email Address: _____
Referred By: _____ **Primary Care Physician:** _____

Marital Status: _____ Single _____ Married _____ Divorced _____ Widowed

1. Reason for referral: _____
2. When was the problem first noted? _____
3. What do you think caused the problem? _____
4. Do you find it difficult to hear in a noisy restaurant or crowded room? _____ Yes _____ No
5. Do you sometimes feel that people mumble or do not speak clearly? _____ Yes _____ No
6. Do you find it difficult to understand dialog while watching television, movies or attending the theater? _____ Yes _____ No
7. Do you find it difficult to understand the speaker at meetings or religious services? _____ Yes _____ No
8. Do you find it difficult to understand soft speech (i.e. whispers)? _____ Yes _____ No
9. Do you have difficulty understanding speech on the telephone? _____ Yes _____ No
10. In what situations would you like to hear better? (List 3)

11. On a scale of 1 to 10, how important is it for you to hear better. (1 being Not Important, 10 being Very Important)

12. On a scale of 1 to 10, how motivated are you to wear and use hearing aids? (1 being Not Motivated, 10 being Very Motivated)

13. On a scale of 1 to 10, how well do you think hearing aids will improve your hearing? (1 being No Improvement, 10 being Significant Improvement)

14. What is your most important consideration regarding hearing aids? (Rank the following factors with 1 as the most important and 4 as the least important. Place an X on the line if the item has no importance to you at all.)

	Hearing aid size and the ability of others not to see the hearing aid(s)
	Improved ability to hear and understand speech
	Improved ability to understand speech in noisy situations
	Cost of the hearing aids

15. Do you prefer hearing aids that: (check one)

Are totally automatic so that you do not have to make any adjustments to them.

Allow you to change the volume and change the listening programs as you see fit

No preference.

16. Look at the pictures of the hearing aids below. Place an X on any of the pictures of hearing aid styles you would not be willing to use. (We will discuss if these choices are appropriate, given your degree of hearing loss and physical shape of your ear.)



BTE



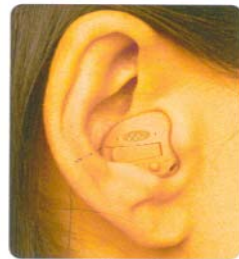
Full Shell



Canal



Mini
BTE



Half Shell/
Low profile



CIC

17. On a scale of 1 to 10, how successful do you think you will be using hearing aids. (1 being Unsuccessful, 10 being Very Successful)