1) Save form to your computer. 2) Complete it. 3) Bring a printed copy with you to your appointment.

Ascent AUDIOLOGY & HEARING

Hearing Health Report

Confidential Client Information

McLean, VA: (703) 942-8110
Lansdowne, VA: (703)723-9672
Falls Church, VA: (703) 485-4531
Rockville, MD: (301) 468-7670
www.HearingAidDoctors.com

1 Patient Information

Name: _____ Date: _____

Address: _____ DOB: _____ Age: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Marital Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse: _____

Gender: _____ Occupation: _____

Primary Insurance: _____ Insured Name: _____ DOB: _____

Primary Insurance ID#: _____ Primary Insurance Group#: _____

Secondary Insurance: _____ Insured Name: _____ DOB: _____

Secondary Insurance ID#: _____ Secondary Insurance Group#: _____

How did you hear about us? ☐Patient ☐Newspaper ☐Direct Mail ☐Community Event ☐Physician Referral ☐Website

2 Medical History

Have you seen a doctor specializing in diseases of the ear: ☐ Yes ☐ No

Please give doctor's name and date seen: _____

Name of primary care or referring physician: _____

Permission to release a copy of test information to physician?: ☐ Yes ☐ No

Have you ever had ear surgery: ☐ Yes ☐ No By whom: _____

Have you ever had your hearing tested: ☐ Yes ☐ No By whom: _____

Is there diabetes in your family: ☐ Yes ☐ No How many prescription drugs do you take daily: ____

Are you taking blood thinners: ☐ Yes ☐ No Do you wear a pacemaker: ☐ Yes ☐ No

3 About Your Hearing

☐Yes ☐No Do you have a deformity of the ear?

☐Yes ☐No Do you have any pain in your ears?

☐Yes ☐No Sudden or rapid hearing loss in the past 90 days?

☐Yes ☐No Sudden or long-term dizziness?

☐Yes ☐No Hearing loss in one ear in the last 90 days?

☐Yes ☐No Have you seen a doctor for wax removal?

☐Yes ☐No Drainage from either ear in the past 90 days?

Which is your poorer ear?

☐Right ☐Left ☐ Same

Does anyone else in your family have a hearing problem: ☐Yes ☐No Who: _____

In what environment does your hearing problem give you the most trouble: _____

4 Hearing Aid Experience

☐ I have a hearing aid and use it regularly in my:
☐Right ear ☐Left ear

☐ I have a hearing aid, but don't use it, or use it only occasionally.

☐ I have tried a hearing aid, but returned it.

☐ I have inquired about hearing aids at another office(s), but did not purchase at that time.

☐ I have never used a hearing aid.

Please complete backside →

5 Hearing Needs Assessment

Please rank the following factors in accordance with how important they are to you when deciding to purchase a hearing aid.

With a '1' being most important and a '4' being least important (Remember to use a 1 , 2 , 3 or 4.) These are your choices:

_____Sound Quality & Clarity _____ Durability/Reliability _____ Cost _____ Appearance

6 Motivation

What motivated you to come in today? _____

_____

_____

7 Motivation Scale

On a scale of 1-10, where do you feel you are (psychologically, emotionally, financially, etc.) regarding doing something about your hearing loss? (Please circle one)

Not Motivated . . . . . **Very Motivated**

8 Self Questionnaire

Please answer "yes, "no", or "sometimes" to each of the following items.
Do not skip a question if you avoid a situation because of a hearing problem.
If you wear a hearing aid(s), please answer the way you hear without the hearing aid(s).

	Yes	No	Sometimes
1. Does your hearing problem cause you to feel frustrated when visiting with friends, relatives or neighbors?	☐	☐	☐
2. Does your hearing problem cause you to feel embarrassed when meeting with new people?	☐	☐	☐
3. Do you have difficulty hearing when someone is soft spoken or speaks at a distance?	☐	☐	☐
4. Does your hearing problem cause you to attend social events or religious services less often than you would like?	☐	☐	☐
5. Does your hearing problem cause you to become fatigued by the end of the day?	☐	☐	☐
6. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
7. Does your hearing problem cause you difficulty when in a restaurant with relatives or friends?	☐	☐	☐
8. Does your hearing problem cause you to have arguments with family members?	☐	☐	☐

9 Release & Authorization

☐ By checking this box and signing below, you allow Ascent Hearing to release all medical information to your insurance carrier(s). You also agree to accept financial responsibility for all charges which are not covered and thus not paid to Ascent Hearing by your insurance carrier(s) for services rendered by our office.

This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of visit.

Signature of Patient or Guarantor: _____ Date: _____