


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

Adult Hearing Health Assessment

Date _____ /_____ /_____

Legal Name _____

Other names, if applicable _____ Pronouns _____

Date of Birth _____ ☐ Male ☐ Female ☐ Other _____

Address _____

_____

Phone _____ Alternate Phone _____

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

May we leave a message at the numbers provided? ☐ Yes ☐ No

Emergency Contact Name _____ Phone Number _____ Relationship _____

Email Address _____

Occupation/Former Occupation _____ Employer _____

Native Language _____ Primary Language _____

Physician's Name _____ Phone _____

Referred by _____

Person Completing this Form _____ Relationship _____

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1-5 Years ☐ 6-10 Years ☐ 10+ Years

Does your hearing fluctuate? ☐ Yes ☐ No Is one ear better than the other? ☐ Right ☐ Left ☐ No

Where do you experience the most difficulty hearing? _____

_____

Have you ever utilized hearing devices? ☐ Yes ☐ No If yes, how long? _____ Make _____ Model _____

Describe your satisfaction _____

_____

Which ear do you most often use on the telephone? ☐ Right ☐ Left ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ Right ☐ Left ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No

If yes, when? _____ Which ear? _____ Name of procedure? _____

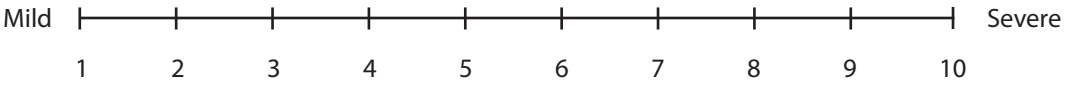
Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce a significant amount of wax? ☐ Yes ☐ No Have you ever had any trauma to the head? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No Have you ever been diagnosed with APD? ☐ Yes ☐ No

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No Do you have a family history of hearing loss? ☐ Yes ☐ No

If yes, what is the level of your disturbance by your tinnitus?



Do you have a history of any of the following?

☐ Measles ☐ Mumps ☐ Diabetes

☐ Frequent Headaches ☐ High Fevers ☐ Meningitis

☐ Allergies ☐ Hemophilia ☐ Circulation Problems

☐ Thyroid Problems ☐ Heart Disease ☐ Pneumonia

☐ Stroke ☐ Other _____

Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months? ☐ Yes ☐ No

If yes, how often have you used a tobacco product in the past 24 months? _____

If yes, what type(s) of products have you used? _____

Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? ☐ Yes ☐ No

If yes, are you feeling dizzy today? ☐ Yes ☐ No

If yes, please describe: _____

If yes, is it accompanied by: ☐ Nausea ☐ Ringing or noises in your ear ☐ Hearing loss ☐ Visual disturbances ☐ Other

Frequency of occurrence: _____

Have you fallen within the past 12 months? ☐ Yes ☐ No

If yes, how many falls have you experienced in the last 12 months? _____

If you have fallen, have you been injured? ☐ Yes ☐ No

Please describe your injury _____

_____

Do you experience visual difficulties or disturbances? ☐ Yes ☐ No

If yes, please describe: _____

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms

☐ Music ☐ Motorcycles ☐ Lawnmower

☐ Other (describe) _____

Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient vision ☐ Good ☐ Fair ☐ Poor

Are there any specific features you are interested in for your hearing solution? _____

_____

_____