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 ____

Insurance:

Primary ______________________ Secondary ______________________

Policy # ______________________ Policy # ______________________

Group # ______________________ Group # ______________________

Subscriber Name ______________________ Subscriber Name ______________________

Subscriber Phone Number & Address ____

Subscriber DOB ______________________ Subscriber DOB ______________________

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

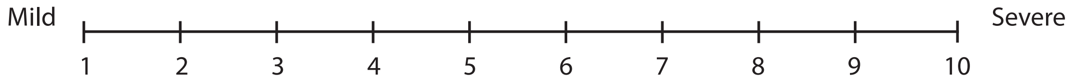
Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ Right ☐ Left ☐ Both ☐ Neither

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 you suffer from tinnitus, what is the level of your disturbance?



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 Ears ☐ 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 ☐ Lawn Mower ☐ Other (describe) ______________________________

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

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

If yes, please describe ______________________________

Have you noticed any memory loss in the past few years? ☐ Yes ☐ No

If yes, please describe ______________________________

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

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