HEARING ASSOCIATES, INC.

18433 ROSCOE BLVD. STE. 204
NORTHRIDGE, CA 91325
AUDIOLOGY & HEARING AID DISPENSING

ADULT EVALUATION & MANAGEMENT RELEVANT HISTORY

PATIENT NAME (last)_________________________________ **(first)** ______________________________________

DATE Of BIRTH: _________________________________ **AGE:** ________________ **DATE:** __________________

HEARING CASE HISTORY	YES	NO	OFFICE USE ONLY: AUD
Do you have difficulty hearing or known hearing loss?			
Are you a current hearing aid(s) user ?			
Do you have ringing or noises in your ear(s)?			
If yes, does it interfere with sleep or normal activities?			
Do you have exposure to loud noises (i.e. work or gun use?)			
Do you have past or recent head injury or ear surgery?			
Do you have ear pain or drainage?			
Do you feel pressure in ear(s) or feel plugged?			
Do you have dizziness, vertigo or balance problems?			
Do you have family members with hearing loss?			
Do you turn the TV up louder than others prefer?			
Do you have difficulty hearing over the telephone?			
Do you miss some words and have to ask people to repeat?			
Do you have to strain to understand conversations in groups?			
Do you have trouble understanding in the presence of noise?			
Do you have trouble understanding in meetings or churches?			
Does it sound like people frequently mumble?			
Do people get annoyed because you don't understand?			
Do you avoid social activities due to your inability to hear?			
Have family members ask you to have your hearing checked?			
Do you have any vision or dexterity problems?			HA Candidate: ___ YES ___ NO

Immediate Complaint/Primary Concern:

For Office Use Only

SUMMARY DETAILS:

Discussed test results & speech audiogram w/ patient?			

CONCLUSIONS/IMPRESSION: SNHL CHL MIXED HL AD AS AU Degree:
SNHL CHL MIXED HL AD AS Degree:

Rx: ___ Medical &/or ENT follow up ____ Hearing Aid Evaluation ____ ABR ____VNG ____month Exam

OTHER: