Audiology Experts
expert care for your hearing

Lisa B. Fell, Au.D.
Kristin Robbins, Au.D.

1261 W. Green Oaks Blvd. Suite 105
Arlington, TX 76013
817.451.4818 | 817.451.4828 [Fax]

BETTER HEARING QUESTIONNAIRE

To better understand your hearing concerns, we ask that you complete this questionnaire.
Thank you for placing your trust in Audiology Experts.

Name ____ **Age** __________

How did you hear about us? ____

Name of spouse/friend with you for your appointment? ____________________________

MEDICAL/AUDIOLOGIC HISTORY	**YES**	**NO**
▪ Will this be the first time you've had a hearing test?	❒	❒
If no, what year were you last tested ____________________		
▪ Have you ever had ear surgery? If yes, when? _______ Which ear? _________ Describe procedure? ____________________	❒	❒
▪ Do you have noises or ringing in your ears? If yes, which ear? _________ For how long?____________________	❒	❒
▪ Did you have chronic ear infections as a child or adult?	❒	❒
▪ Do you have a family history of hearing loss?	❒	❒
▪ Have you been exposed to loud noises in your life?	❒	❒
▪ Have you had any trauma to the head?	❒	❒
▪ Do you have sinus or allergy problems?	❒	❒
▪ Do you experience dizziness or vertigo?	❒	❒
▪ In which ear do you hear **better**? circle: left right same. Why do you perceive a difference? ____________________		
▪ What do you believe caused your hearing problem? ____________________		
▪ Do you wear hearing aids?	❒	❒
If yes, circle: left only right only both ears		
What year did you buy your hearing aids? ____________________		
Where did you buy your hearing aids? ____________________		
Do you have any problems with your hearing aids?	❒	❒
If yes, explain: ____________________		

- Why have you decided to have your hearing tested at this time?
  - ❒ I feel my hearing is poor and may need to be aided.
  - ❒ Family/friends have suggested I have my hearing checked.
  - ❒ Other reason/explain:

____

(Please complete backside of this form)

MEDICAL HISTORY

Have you had or do you currently have any of the following:

High blood pressure	Heart disease	Stroke
Arthritis	Diabetes	Kidney disease
Cancer	Mumps	Measles
Meningitis	Other diagnosis:	Other diagnosis:

Please list any medications (or provide a list) that you take:

____

____

HEARING DIFFICULTY QUESTIONNAIRE

Indicate your ability to hear (Hearing Quality) in the following listening situations and rate the importance of that listening situation to you. Select one: ❒ with hearing aids ❒ without hearing aids.

Circle the appropriate number in columns two and three.

LISTENING SITUATION	HEARING QUALITY			IMPORTANCE TO YOU		
	POOR		NORMAL	NOT	SOMEWHAT	VERY
QUIET (one on one conversation)	1	2	3	1	2	3
WHISPER	1	2	3	1	2	3
TELEVISION	1	2	3	1	2	3
Do others complain the TV volume is too loud?	YES ❒	NO❒				
RESTAURANTS	1	2	3	1	2	3
CHURCH	1	2	3	1	2	3
MEETING/GROUPS	1	2	3	1	2	3
Do you avoid/dislike social situations b/c of difficulty understanding?	YES ❒	NO❒				
WORK PLACE	1	2	3	1	2	3
TELEPHONE	1	2	3	1	2	3
CAR	1	2	3	1	2	3
MALE VOICE	1	2	3	1	2	3
FEMALE VOICE	1	2	3	1	2	3
CHILD'S VOICE	1	2	3	1	2	3
OTHER (please explain below)	1	2	3	1	2	3

____

ASSESSMENT OF PRIORITIES RELATING TO HEARING CORRECTION

Please rank, in order of importance, the factors listed below that you would consider when purchasing hearing instruments. Rank using numbers 1-5 with 1 being the most important to you and rank 5 being the least important to you.

_____ Ability to understanding speech better

_____ Ability to understanding speech better in noisy environments

_____ Inconspicuous appearance

_____ Physical comfort of the instruments

_____ Cost of the hearing instruments

Patient Signature ___________________________________ **Date:** _________________________

Thank you for helping us help you hear better!