Ashley Engle, Au.D.
Audiology & Hearing Aid Services, LLC.

☐ Do NOT resuscitate on file ☐ Claustrophobic ☐ Latex Allergy

Medical / Audiologic History

How is your general health? _____
History of Diabetes? _____
Do you smoke? _____
Recent hospitalizations/ surgeries? _____
Any past ear surgeries? _____
History of ear disease? _____
Family history of hearing loss? _____
History of trauma to the head? _____
Do you have dizziness, vertigo, or loss of balance? _____
If you answered yes to the previous question, please describe when it began, the duration, how often it occurs and whether it is accompanied by nausea or vomiting?_____
_____
Do you have any tinnitus (ringing, buzzing, hissing)? _____
Which ear? _____ When did it begin? _____
How frequent? _____ What is the duration? _____
History of exposure to noise? _____
Have you ever worn a hearing aid? ○ No ○ Yes // ○ Left ear only ○ Right ear only ○ Both ears

Hearing Difficulty Questionnaire

Listening Situation	Hearing Quality (Poor 1 2 3 4 5 Normal)	Importance to you (Not 1 Somewhat 2 Very 3)
Quiet (one on one conversation)	1 2 3 4 5	1 2 3
Television	1 2 3 4 5	1 2 3
Leisure Activities	1 2 3 4 5	1 2 3
Restaurants	1 2 3 4 5	1 2 3
Church	1 2 3 4 5	1 2 3
Meetings / Groups	1 2 3 4 5	1 2 3
Work Place	1 2 3 4 5	1 2 3
Telephone	1 2 3 4 5	1 2 3
Car	1 2 3 4 5	1 2 3
Male Voice	1 2 3 4 5	1 2 3
Female Voice	1 2 3 4 5	1 2 3
Child's Voice	1 2 3 4 5	1 2 3

*Some hearing aids offer connectivity directly to your cell phone, for that reason, please indicate the type of cell phone you have:_____

Patient's Signature Date

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