Hearing Aid Specialists

of the Central Coast
12326 Los Osos Valley Rd, San Luis Obispo, CA 93405
Ph: (805) 439-3586

DATE: _____

FULL NAME: _____SPOUSE'S/PARTNER'S NAME: _____

MAILING ADDRESS: _____

STREET ADDRESS (IF USING P.O. BOX): _____

CITY: _____ STATE: _____ ZIP: _____EMAIL:_____

PHONE NUMBER(S): _____ DATE OF BIRTH: _____ AGE: _____

TYPE OF INSURANCE: _____

PRIMARY CARE PHYSICIAN: _____

PLEASE ANSWER THESE FEW QUESTIONS TO THE BEST OF YOUR ABILITY

1. How long have you been aware of communication difficulties? _____
2. In which ear do you feel you hear better? ……. Right Left Don't Know
3. Do you have difficulty understanding on the phone?…… Yes No
4. Do you have to turn the TV louder than others in the room? …… Yes No
5. Do you feel you hear but do not always understand the words? …… Yes No
6. Do you have difficulty understanding in a noisy restaurant? …… Yes No
7. Do any of your blood relatives have a hearing loss? ……. Yes No
8. Do you have a history of chronic exposure to loud noise? …… Yes No
9. Have you ever seen a doctor for earwax removal? …… Yes No
10. Did you serve in the military? ……. Yes No
11. What is/was your occupation? _____ Retired? ……. Yes No
12. Have you ever had a hearing test before? …… Yes No
    If yes, where? _____ When? _____
13. Do you now, or have you ever worn a hearing aid? …… Yes No
14. In what situation do you have the most difficulty hearing? _____
15. How did you hear about Hearing Aid Specialists? TV / Newspaper / Yellow Pages / Internet
    Friend / Other _____
16. Are you interested in financing? ……. Yes No

STOP HERE **STOP HERE**

CASE HISTORY – FOR <u>SPECIALIST</u> TO COMPLETE

1. History of ear infections……Yes No
2. Drainage (within 90 days)…… Yes No
3. Pain or discomfort in the ear…… Yes No
4. Feeling of aural fullness or pressure in the ear……. Yes No
5. Former ear surgeries……. Yes No
6. Sudden hearing loss (within 90 days) ……. Yes No
7. Unilateral (one side only) hearing loss, sudden or recent onset (within 90 days)…… Yes No
8. Acute or chronic dizziness ……Yes No
9. Tinnitus (any head noises) ……Yes No
10. Head injury / trauma …… Yes No
11. Acoustic trauma…… Yes No
12. Stroke or T.I.A. _____
13. History of noise exposure explained _____
14. Other medical info _____

_____

15. Current hearing aid info _____

_____

16. Vision Issues: Glaucoma ____Yes ___ No Macular Degeneration ____ Yes ____No
17. Manual Dexterity/Strength: _____
18. Feeling in the finger tips? Extended V.C. Cap _____ Screw Set V.C _____ Other V.C _____
19. Prescription meds such as: HBP ____ Diuretics___ Arthritis meds ____ Antibiotics ____ Diabetes_____

    Allergies: _____
20. Surgery within the past 12 months? _____

INSPECTION OF AUDITORY CANAL

External Ear _____ Deformities? _____ Yes ____ No

Ear Canal Inspection: _____Clear ____ Trace of Cerumen ____ Excessive Cerumen ____ Canal blocked

_____ Foreign Body ____ Other _____

Canal Size: Small / Medium / Large Canal Shape: Straight / Curved

Air bone gap greater than 15 dB? _____

Specialist comments: _____

_____

_____