HEARING AID CENTER

HEARING REHABILITATION PROGRAM

Name _____ Date of Birth _____
Street Address _____
Town _____ Zip Home Phone
Work Phone Occupation

Background information

Have you ever had your hearing evaluated? Where?
When? Recommendations (if any at that time?)

When did you first notice hearing difficulty?
Have you had recent headaches, ear infections or surgery?

Ever worked in a noisy place? Diabetic?
Is there any additional information you would like us to know?

Physician Address
How have you come to us today? Mailing Referred by Dr.
Tv Ad Other
Insurance Carrier Subscriber ID

Communication Difficulties

Do communication difficulties cause friends or family to become frustrated?
Do communication difficulties reduce your enjoyment of TV?
Do you feel your hearing hampers your personal or social life?
Do you hear but have difficulty understanding?
In what environment would you most enjoy improved hearing?

If amplification could help you hear better, are you ready for that help?

Amplification History

Have you ever used hearing aids? (if yes, please complete the following)
Type(s) Ear(s) fit When?
Performance of present hearing instruments

Caring for your Hearing