BERGER AUDIOLOGY
Your First Choice In Hearing Healthcare

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NAME: ______________________ **DATE:** ______________________

MEDICAL & HEARING HISTORY	YES	NO
Is this your first hearing test?		
Have you ever had ear surgery?		
Do you have a history of ear infections?		
Do you have a family history of hearing loss?		
Have you ever worked around any noise?		
Have you had head trauma?		
Have you experienced dizziness or lightheadedness?		
If so, what direction do you spin?	R	L
If so, do you spin or does the room spin?	Me	Room
Do you notice ringing/noise in your ears?		
If so, does it keep you awake at night?		
If so, does it bother you during the day?		
If so, is it worse in one ear? Which one?	R	L
List ALL routine medications on back		
List ALL previous surgeries on back		
Do you think you have hearing loss?		
If so, which ear or both?		
If so, how long have you noticed this? **(circle below)**		
Less than 1 yr 1 – 5 yrs More than 5 years		
Do you have difficulty understanding in a group?		
Do you have difficulty understanding tv or radio?		
Are you withdrawing from conversation?		
Do you feel frustrated trying to listen?		
Do you avoid going places?		
Do you ask for people to repeat?		
Do you have difficulty listening to worship services?		
Do you have difficulty listening in a restaurant?		
Do you now, or have you ever smoked?		
Do you suffer from depression?		

Why have you decided to have your hearing tested today?

- I want to be sure it's normal.
- My family suggested I do this.
- I feel my hearing is poor.
- I think I need hearing aids.
- My employer has required it.

Please list situations in which you would like to hear and/or understand better:

1. ______________________
2. ______________________
3. ______________________
4. ______________________

If we were to find out through this evaluation that you could be helped by hearing instruments, are you ready for that help?

YES NO MAYBE

Below is a list of factors to consider regarding hearing instrument use. Please rank these in the order of preference for you.

__ Understand speech better
__ Maintenance expense
__ Follow up Care
__ Comfort
__ Batteries
__ Cost
__ Cosmetics
__ Function in noisy places

Have you worn hearing instruments before? ________
For how long did you wear them? ______________
Were you satisfied with them? Yes No Sometimes
Which ear did you wear them? Right Left Both