EverClear Hearing Products, LLC

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Name_____ DOB_____ AGE_____ Gender___

Medical Information:

Medications/Supplements: _____
Allergies: _____

Occupation: _____Former Occupation: _____

Do you smoke? Y / N Year started_____
If used to, but quit, what year you quit _____
Do you wear glasses? Y / N All day_____ Occasionally_____

With whom do you live? Alone Spouse Mother Father Children Siblings
Are you in either? Assisted Living Nursing Home (Circle)
Have you had or currently being treated for the following:

Diabetes	**Y**	**N**
Chemotherapy –last six months	**Y**	**N**
Compromised immune system	**Y**	**N**
Heart Disease	**Y**	**N**
Kidney Disease	**Y**	**N**
Radiation Treatment	**Y**	**N**
Stroke	**Y**	**N**

Do you <u>currently</u> have?

Pain or discomfort in your ears	**Y**	**N**
Dizziness	**Y**	**N**
Fullness or pressure in your ears	**Y**	**N**
Visible deformity of the ear	**Y**	**N**
Cerumen wax) or foreign body	**Y**	**N**
Tinnitus (ringing, noise in ears)	**Y**	**N**

If yes, right_____ left_____ both_____

How annoying is your tinnitus?

Not annoying (circle one number) Very annoying

0 1 2 3 4 5

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Have you had?

Excessive noise exposure, ever **Y N**

Military___ Hunting ___Work____ Lawn care ___Power Tools_____ Music____

Describe_____

Drainage from your ears in the last 90 days **Y N**

Sudden hearing loss in the last 90 days **Y N**

Unilateral hearing loss in the last 90 days **Y N Right or Left**

Ear Surgery **Y N**

If yes, when_____ Reason_____

Physician who performed surgery_____ _____

CT/MRI Scans related to hearing issues **Y N**

If yes, when_____ Facility_____

Family history of hearing loss, whom **Y N _____**

Type of hearing loss, if known_____

Hearing Aid History

Have you had your hearing previously evaluated? **Y N**

When _____By whom _____ Results _____

How long has your hearing been bothersome? _____

Is one ear worse than the other? Y N If yes, Right_____ Left_____

Do you now or in the past wear/worn hearing aids? **Y N When? _____**

Make _____ Model _____ Style_____ Binaural/Monaural

Dispenser_____

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<u>Hearing History</u>:

Due to your hearing, do you have? (Circle one)

Difficulty talking on the phone:	**Always**	**Sometimes**	**Never**
Others complaining TV/radio is too loud	**Always**	**Sometimes**	**Never**
Trouble with conversation in restaurants	**Always**	**Sometimes**	**Never**
Social life limitations	**Always**	**Sometimes**	**Never**
People repeat themselves	**Always**	**Sometimes**	**Never**
Difficulty hearing in noise	**Always**	**Sometimes**	**Never**
Trouble hearing women or children	**Always**	**Sometimes**	**Never**
Difficulty understanding conversation	**Always**	**Sometimes**	**Never**
Feel people are mumbling	**Always**	**Sometimes**	**Never**
Stress, due to hearing difficulties	**Always**	**Sometimes**	**Never**

How would <u>you</u> rate your overall hearing as it affects your quality of life?

Not affecting life				**affecting life**				**severely affecting**	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

<u>Companion/spouse</u> rating of overall hearing as it affects your quality of life?

Not affecting life				**affecting life**				**severely affecting**	
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

Please provide the top 3 listening situations you would like to hear better in.

1. **_____**
2. **_____**
3. **_____**