



# 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? 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? Received Mailing \_\_\_\_\_ Referred by my 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*