AUDIOLOGY
OF NASSAU COUNTY PLLC

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Hearing Health Assessment

If someone besides the patient is completing this form;
Name Relationship to Patient

Patient Name (First / MI / Last) Date mm / dd / yy

Specifically, how can we help you?

How long has it been since your last hearing test?

How many years ago did you purchase your technology? 1-3 years 3-5 years 5+ years

MEDICAL: Internal Use Only

PQRS RX Dizzy Diabetes Tobacco Fall/Risk Communication Tinnitus

Tinnitus: On a scale of 1-10, how do you rate your tinnitus?

Dizziness: On a scale of 1-10, how do you rate your balance?

Communication: On a scale of 1-10, how do you rate your ability to communicate?

My current hearing technology performance is satisfactory

	Always	Sometimes	Never
While in background noise			
At religious services			
In the car			
On the phone			
In a conference room			
In a restaurant			

	Always	Sometimes	Never
While listening to music			
While watching TV			
In group conversations			
In conversations with spouse			
In conversations with children			

Please tell us where you would like to hear better:

1.
2.
3.

Current, and if different, ***desired*** lifestyle

Active Lifestyle (Frequent background noise)	Current	Desired
Casual Lifestyle (Occasional background noise)	Current	Desired
Quiet Lifestyle (Limited background noise)	Current	Desired
Very Quiet Lifestyle (Rare background noise)	Current	Desired

My current hearing technology is:

	Always	Sometimes	Never
Comfortable			
Has feedback or makes whistling noises			
Provides hearing confidence on a day-to-day basis			
Is cosmetically appealing			

If amplification is deemed necessary, **what is most important to you?** 1 = Least important 5 = Most important

Visibility

Expense

Ease of Use

Ability to wear in most situations
(i.e. theatres, movies, on the phone, during exercise)

Minimal amount of maintenance
(i.e. change battery, change programs, cleaning)

Hearing Health Assessment

If someone other than the patient is completing this form:

Name

Relationship to Patient

Patient Name
First MI Last

Date / /
mm dd yy

Specifically, how can we help you?

How long has it been since your last hearing test?

COMMUNICATION

Often | Sometimes | Rarely

Self Questionnaire: Does a hearing problem:

Make it difficult for you to converse on the telephone?

Cause others to complain that you turn up the television or radio too loud?

Cause you to have difficulty following conversations in a restaurant?

Limit or hamper your personal or social life?

Cause you to have to ask people to repeat themselves?

Cause you to have difficulty hearing when in the presence of background noise?

Cause you to have difficulty hearing women's or children's voices?

Cause you to hear people speak but fail to understand what they are saying?

Cause you to feel as though others mumble?

Cause you to feel stressed or tired when listening for long periods of time?

Please tell us where you would like to hear better:

1.
2.
3.

Listening Environments and Activity Participation:

Watching TV
Outdoors
Place of Worship
On the Phone
Talking in Groups
Crowded/Noisy Place
Concerts
Lectures
Business Meetings
Exercise Activities
Conversations with soft voices

Hearing Aid Experience?: YES NO

If amplification is deemed necessary, **what is most important to you?** On a scale of 1-5 with 1 being least important and 5 being most important.

Visibility

Expense

Ease of Use

Ability to wear in most situations
(i.e. theatres, movies, on the phone, during exercise)

Minimal amount of maintenance
(i.e. change battery, change programs, cleaning)

How motivated are you to address the issues that brought you in today?

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Dizziness: On a scale of 1-10, how do you rate your balance?

Communication: On a scale of 1-10, how do you rate your ability to communicate?

WITHOUT TECHNOLOGY