


ECKELMANN-TAYLOR SPEECH AND HEARING CLINIC
Illinois State University

Adult Hearing Health Assessment

Date _____/_____/_____

Name _____

Date-of-Birth _____ Age _____ ☐ Male ☐ Female

Address _____

_____

Phone _____ Alternate Phone _____

Home Work Cell (CIRCLE ONE) Home Work Cell (CIRCLE ONE)

Email Address _____

Occupation/Former Occupation _____ Employer _____

Highest Level of Education Completed _____

Name of Spouse or Nearest Relative _____

Native Language _____ Primary Language _____

Physician's Name _____ Phone _____

Referred by _____

Person Completing this Form _____ Relationship _____

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1-5 Years ☐ 5-10 Years ☐ 10+ Years

Does your hearing fluctuate? ☐ Yes ☐ No Is one ear better than the other? ☐ Right ☐ Left ☐ No

Where do you experience the most difficulty hearing? _____

_____

Have you ever utilized hearing devices? ☐ Yes ☐ No If YES, how long? _____ Make _____ Model _____

Describe your satisfaction _____

_____

Which ear do you most often use on the telephone? ☐ Right ☐ Left ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ Right ☐ Left ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No

If YES, when? _____ Which ear _____ Name of procedure _____

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No Have you had chronic ear infections? ☐ Yes ☐ No

Do your ears produce a significant amount of wax? ☐ Yes ☐ No Have you ever had any trauma to the head? ☐ Yes ☐ No

Are you experiencing any pressure in your ears? ☐ Yes ☐ No Do you suffer from dizziness? ☐ Yes ☐ No

Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No Do you have a family history of hearing loss? ☐ Yes ☐ No

Are you currently using any medications? ☐ Yes ☐ No

If YES, please list _____

Do you have a history of any of the following?

☐ Measles	☐ Mumps	☐ Diabetes
☐ Frequent Headaches	☐ High Fevers	☐ Menengitis
☐ Allergies	☐ Hemophilia	☐ Circulation Problems
☐ Thyroid Problems	☐ Heart Disease	☐ Pneumonia
☐ Stroke	☐ Other _____	

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace	☐ Military	☐ Firearms
☐ Music	☐ Motorcycles	☐ Lawnmower

☐ Other (describe) _____

Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient Vision ☐ Good ☐ Fair ☐ Poor

Are there any specific features you are interested in for your hearing solution? _____

_____

_____