NOBILE
Hearing Aid Center

HEARING HEALTH REPORT

(Please Print)

Date: ☐☐/☐☐/☐☐

Name: _____ ☐ Male ☐ Female
FIRST MIDDLE INITIAL LAST

Marital Status: ☐ Single ☐ Married ☐ Widowed Name of Spouse: _____

Permanent Address: _____
STREET CITY STATE ZIP

Seasonal Address (if applicable): _____
STREET CITY STATE ZIP

Phone: ☐☐☐-☐☐☐-☐☐☐☐ Birthdate: ☐☐/☐☐/☐☐ Age: ☐☐

Are you retired? ☐ Yes ☐ No **If yes,** where did you work? _____

If no, where do you work currently? _____

Observing party: _____
NAME RELATIONSHIP

Email Address: _____

Referral source (check one): ❑ Doctor Referral ❑ Customer Referral ❑ Friend/Family ❑ Newspaper ❑ Mail
❑ Phone ❑ Web ❑ Yellow Pages ❑ Store Sign ❑ Walk-in ❑ Other _____

Do you know of anyone who can benefit from a complimentary hearing screening?

Hearing Health History

What kind of problems are you having with your hearing? _____

When did you first notice that you were having difficulty with your hearing? _____

In which ear do you have greater difficulty hearing? ❑ Right ❑ Left

Will this be the first time you've had your hearing tested? ❑ Yes ❑ No

Do you hear people speaking, but have difficulty understanding the words? ❑ Yes ❑ No

Do you have difficulty understanding in a large crowd? ❑ Yes ❑ No

Do you have any particular difficulty understanding your children or grandchildren? ❑ Yes ❑ No

Do you have to turn the radio or television up louder than normal? ❑ Yes ❑ No

Do you have any problems when listening in church, synagogue or in a large lecture hall? ❑ Yes ❑ No

Do you have difficulty understanding conversation in the car? ❑ Yes ❑ No

Do you have any ringing in your ear(s)? ❑ Yes ❑ No If yes, which ear? ❑ Right ❑ Left ❑ Both

FDA Questions *(Leave this section blank)*

*Visible congenital or traumatic deformity of the ear? ☐ Yes ☐ No
*Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? ☐ Yes ☐ No
*Any history of, or active drainage from, the ear within the previous 90 days? ☐ Yes ☐ No
*Any history of sudden or rapidly progressive hearing loss within the previous 90 days? ☐ Yes ☐ No
*Have you expreienced any acute or chronic dizziness? ☐ Yes ☐ No
*Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? ☐ Yes ☐ No
*Have you experienced any pain or discomfort? ☐ Yes ☐ No
*Audiometric air-bone gap equal to, or greater than 15dB at 500 Hz, 1000 Hz, and 2000Hz? ☐ Yes ☐ No

Hearing Health Care Professional: _____ License #: _____

***If answer is "Yes" to any of these questions, patient must be referred to a physician or ear specialist prior to a hearing instrument fitting.**