Hearing Care Specialists, Inc.

PATIENT NAME:

Hearing Aid History

1. Do you currently wear hearing aid/s? YES NO (if no, skip to question 10)
2. How long have you been wearing hearing aid/s? ______________________________
3. In which ear do you use your hearing aid/s? Left ear Right ear Both
4. How old is/are your current aid/s? ______________________________

   Make/Model______________________________ Style______________________________

   Make/Model______________________________ Style______________________________
5. How many hours a day do you use your hearing aid/s?______________________________
6. Do you use your hearing aid/s on the telephone? YES NO
7. Does your hearing aid have FEEDBACK (whistling)? YES NO
8. Do your hearing aids perform well in noisy situations? YES NO

   If no, please explain:
9. Are you generally satisfied with your hearing aids? YES NO

   If not, why?
10. What would you like to learn from your visit today?