Hearing Health History:

Patient Name: ______________________ **Date:** ________

ENT Consulted? ☐ Yes ☐ No If yes, Name of ENT: ______________________________

Otological History:

History of Ear Infections	☐ Yes ☐ No	Perforated Eardrum	☐ Yes ☐ No
Ear Disease	☐ Yes ☐ No	Noises in the ears	☐ Yes ☐ No
Ear Pain	☐ Yes ☐ No	Facial Numbness	☐ Yes ☐ No
Ear Discharge	☐ Yes ☐ No	Previous Hearing Test	☐ Yes ☐ No
Ear Fullness/Pressure	☐ Yes ☐ No	Family History of HL	☐ Yes ☐ No
Ear Surgery/s	☐ Yes ☐ No	MRI/CT of Head or Ears	☐ Yes ☐ No
Dizziness/Vertigo in past 90 days	☐ Yes ☐ No	Sinus Allergies	☐ Yes ☐ No

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Noise Exposure ☐ Yes ☐ No If yes: ☐ Military ☐ Industrial ☐ Recreational Noise

Rifle Use: ☐ Left handed ☐ Right handed ☐ Do not use rifle

Hearing Protection Use ☐ Yes ☐ No Comments ______________________________

Previous Hearing Aid Use ☐ Yes ☐ No Make/Model/Year __________________________

Other History:

Diabetes	☐ Yes ☐ No	Stroke(s)	☐ Yes ☐ No
Headaches	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No
Heart Disease	☐ Yes ☐ No	Memory Loss	☐ Yes ☐ No
Head Trauma	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Implantable Medical Device(s)	☐ Yes ☐ No	Blood Thinners	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Dementia	☐ Yes ☐ No
Radiation to Head/Neck	☐ Yes ☐ No	Tobacco Use	☐ Yes ☐ No
Compromised Immune System	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Falling	☐ Yes ☐ No		

Other Significant Health Issue/s: ____

Personal Hearing Information:

Patient Name: ______________________________ **Date:** _________

Do you have difficulty hearing:

In a meeting or group situation	☐ Yes ☐ No
The TV	☐ Yes ☐ N
On the telephone	☐ Yes ☐ No
In loud noise	☐ Yes ☐ No
In moderate noise	☐ Yes ☐ No
At a distance	☐ Yes ☐ No
At church	☐ Yes ☐ No
In a car	☐ Yes ☐ No
A store clerk/waitress	☐ Yes ☐ No
Do people mumble?	☐ Yes ☐ No
Is it more difficulty to hear children than adult voices?	☐ Yes ☐ No
Are you asking people to repeat themselves regularly?	☐ Yes ☐ No
Do family members think you have difficulty hearing?	☐ Yes ☐ No
Do communication challenges cause stress at home?	☐ Yes ☐ No
Do you avoid social situations because of communication challenges?	☐ Yes ☐ No

Hearing Needs Assessment

Tell us the main situation/s you would like to improve communication. Then tell us what happens in this situation? How do you currently respond to it? How do you feel?

Communication Situations/Challenges Example: Difficulty hearing in restaurants	**Impact on Quality of Life** Example: I withdraw from conversations/ I feel left out
1.	
2.	
3.	

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Name: ____ Date: ___________________

HHIE Screen- Initial visit

Answer YES, NO or SOMETIMES for each question. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer according to the way you hear with the aid.

	(4) Yes	(0) No	(2) Sometimes
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	[ ]	[ ]	[ ]
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	[ ]	[ ]	[ ]
3. Do you have difficulty hearing when someone speaks in a whisper?	[ ]	[ ]	[ ]
4. Do you feel handicapped by a hearing problem?			
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	[ ]	[ ]	[ ]
6. Does a hearing problem cause you to attend religious services less often than you would like?	[ ]	[ ]	[ ]
7. Does a hearing problem cause you to have arguments with family members?	[ ]	[ ]	[ ]
8. Does a hearing problem cause you difficulty when listening to TV of radio?	[ ]	[ ]	[ ]
9. Do you feel any difficult with you hearing limits or hampers your personal or social life?	[ ]	[ ]	[ ]
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	[ ]	[ ]	[ ]
Total	___	___	___

0-8= No HH, 10-24= Mild to moderate HH, 26-40= Severe HH

Adapted from Ventry I., Weinstein B., Identification of elderly people with hearing problems. ASHA, 1083; 25:37-42

S:Forms:HHIEscreen