Virginia Hearing Center

Case History - Patient Form

Patient Name: ______________________________ Date: ______________

Previous hearing aids? ☐ Yes ☐ No

When was your hearing last tested? Date: ______________

Have you previously had hearing aids? ☐ Yes ☐ No

Are you having trouble hearing on a regular basis? ☐ Yes ☐ No

In what situations is it most difficult for you to hear? ______________________________

Do you have difficulty hearing at home? ☐ Yes ☐ No

Do you have difficulty hearing during recreational activities, groups or meetings? ☐ Yes ☐ No

Do you have difficulty listening to music? ☐ Yes ☐ No

Do you have difficulty with movies, TV or at the theater? ☐ Yes ☐ No

Do you have difficulty hearing in noisy environments? ☐ Yes ☐ No

Do you have difficulty hearing at work? ☐ Yes ☐ No

Do you have difficulty hearing on the phone, either landline or cellphone? ☐ Yes ☐ No

Do you have difficulty hearing at lectures or religious services? ☐ Yes ☐ No

Do you have difficulty using technology, like cellphones, computers or tablets? ☐ Yes ☐ No

Are there any other environments where it is difficult for you to hear? ______________________________

How would you describe your hearing goals?

1. ______________________________

2. ______________________________

3. ______________________________