



Hearing Care of Carson City, LTD.

Hearing Aids & Audiology

Our concern is your hearing. To better help you, we ask that you fill out this questionnaire to describe the ways your hearing affects you. Please complete the front and back side and return the completed form to the front desk.

Thank you for placing your trust in us for all of your hearing needs.

Hearing Care of Carson City, Ltd.

Hearing Aids & Audiology

Mark Weeks, M.C.D.

CCC Audiologist

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Doctor of Audiology

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HEARING EVALUATION PROFILE

Today's Date

Name

Date Of Birth

Address

City

State

Zip

Phone Number

Alt. Phone #

Email

Medical Insurance Company

Insurance Id # Or Social Security #

Name Of Local Doctor

Name Of Spouse Or Friend With You Today

Occupation

How Did You Hear About Us

Hearing Aids/Services Will Be Paid By

Myself

Other

It Is Our Policy That A ½ (One-Half) Deposit Is Due When The Hearing Aids Are Ordered And A Final Payment Is Due When The Hearing Aids Are Fitted. Please Advise Us If Special Arrangements Need To Be Made.

MEDICAL AND AUDIOLOGIC HISTORY

Will this be the first time you've had a hearing test Yes No If no, when was your last evaluation

What were the results: Normal hearing Hearing Loss Other (Please explain)

In which ear to you hear better: Right Left Unsure Do you have tinnitus (noises or ringing your ears)? Yes No

If yes, please check all that describe the tinnits: Constant Occasional Frequent Both ears Right Ear Left Ear

Do you ever get dizzy? Yes No If yes, please describe your dizziness, including frequency, duration, triggers, etc:

Have you been exposed to loud sounds in your life? Yes No If yes, please describe:

What do you believe caused your hearing problem?

The ability to hear is as important as it is complex. Many variables must be considered when diagnosing and treating ear related disorders.

Please check all that apply to you:

Head trauma	Ear canals that itch	Pain in the Ear	Facial numbness/tingling	Family history of hearing loss
Headaches	Feeling of "fullness" in the ear	Drainage from the ear	Chronic ear infections as a child or adult	
Ear surgery: When:	Which Ear:	Right	Left	Other

Has a spouse or friend told you that you don't hear well Yes No

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

Each patients hearing is unique. Please help us understand yours. When do you have difficulty understanding conversations? Please check all that apply:

In a large crowd	In a restaurant	With your spouse/friends	With children/grandchildren
In small groups	Outdoors	At a distance	On the phone/cell phone

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

Do you ever have to concentrate so much to listen that you become tired from the effort? Yes No

Do you currently wear hearing aids? Yes No

If you wear hearing aids, do you have any problems with them? Yes No If yes, please explain:

What motivated you to have your hearing evaluated at this time?

I feel my hearing is poor and may need to be aided. Family/friends have suggested I have my hearing checked.

Other reason, please explain: