EverClear Hearing Products, LLC

2215 E Clairemont Ave, Ste 5, Eau Claire, Wi 54701 P 715-831-0289 * F 715-831-4722

Name				DOB	AC	GE	Gende	er
Medical Informa	ition:							
Please list any b	lood thinn	ers:						
Allergies:								
Occupation:			Fo	rmer Oco	cupation	:		
	ou smoke? Y / N Year star							
	ed to, but							
Do you drink alc								
Do you wear gla	sses? Y / N All day			Occ	_ Occasionally			
With whom do y Are you in eithe Have you had or	r? Assi	isted Livin	g	Nurs	ing Hom			iblings
Diabetes					Y	Ν		
	Chemotherapy –last six months				Y	Ν		
Compromised immune system					Y	Ν		
	Heart Disease				Y			
Kidney Disease					Y			
Radiation Treatment					Y			
Stroke					Y	Ν		
Do you <u>currently</u>								
Pain or discomfort in your ears					Y	N		
Dizziness					Y	N		
Fullness or pressure in your ears					Ŷ	N		
Visible deformity of the ear				Ŷ	N			
Cerumen wax) or foreign body				Ŷ	N			
Tinnitus (ringing, noise in ears)					Y	Ν		
-	es, right			both				
	ying is you						-	
Not annoyi	-	-	one n	umber)	-	-	annoyir _	ng
0	1	2		3	4	1	5	

Have you had?						
Excessive noise exposure, <u>ever</u>	Y	Ν				
Military HuntingWork Lawn care	itary HuntingWork Lawn carePower Tools_					
Describe						
Drainage from your ears in the last 90 days	Y	Ν				
Sudden hearing loss in the last 90 days	Y	Ν				
Unilateral hearing loss in the last 90 days	Ν	Right or Left				
Ear Surgery	Ν					
If yes, when Rea	son					
Physician who performed surgery						
CT/MRI Scans related to hearing issues						
If yes, when Faci						
Family history of hearing loss, whom	Y	Ν_				
Type of hearing loss, if known						
Hearing Aid History						
Have you had your hearing previously evaluated?	γ γ	Ν				
WhenBy whom						
How long has your hearing been bothersome?						
Is one ear worse than the other? Y N If yes,	Right		Left			
Do you now or in the past wear/worn hearing aid	ls? Y	Ν	When?			
Make Model Style_		Bina	ural/Monaural			
Dispenser						
Experience with hearing aids?						
· · · · · · · · · · · · · · · · · · ·						
Are you familiar with the levels and styles of hear	ring aids?	Y	Ν			
Are you familiar with any Hearing Aid Manufactu	rers?	Υ	Ν			
Do you have any coverage for hearing aids?		Y	Ν			
Would you like us to check coverage for you?		Y	Ν			
Do you have a budget you need to work within?		Y	Ν			

<u>Cell phone</u>	<u> </u>	Iphon	e		/Android	I				
Due to you	Due to your hearing, do you have?					(Circle one)				
Difficulty talking on the phone:					Always	Sometimes	Never			
Others complaining TV/radio is too loud					Always	Sometimes	Never			
Trou	Trouble with conversation in restaurants					Sometimes	Never			
Soci	Social life limitations				Always	Sometimes	Never			
Рео	People repeat themselves					Sometimes	Never			
Diff	culty heari	ng in noise			Always	Sometimes	Never			
Trou	uble hearing	g women or	children		Always	Sometimes	Never			
Diff	culty unde	rstanding co	onversatio	on	Always	Sometimes	Never			
Feel	Feel people are mumbling					Sometimes	Never			
Stre	Stress, due to hearing difficulties					Sometimes	Never			
How would youHow would yourate your overall hearing as it affects your quality of life?Not affecting lifeaffecting life12345678910							/ affecting			
<u>Companion/spouse</u> rating of overall hearing as it affects your quality of life? Not affecting life affecting life severely affecting										
1 2	3	4	5	6	7	8 9	9 10			
1 2		p 3 listening				e to hear bet	tter in.			
Activities you have quit due to hearing difficulty:										
If hearing aids are recommended, are you ready to accept help with aids?										

Yes ______No ______Maybe _____