



ANNUAL EVALUATION AND HEARING AID CHECK FORM

NAME: Robert L. Smith DATE: 12/30/2012

HISTORY UPDATE

- 1. Do you feel that your hearing has changed?
2. If you have previously reported any noises or ringing in your ears, has this conditioned changed?
3. Do you have any pain or discomfort in your ears?
4. Have you had any recent ear surgeries or medical problems with your ears?
5. In the last 90 days have you experienced any dizziness or difficulty with your balance?

CURRENT HEARING AID USE

- 6. Do you wear your hearing aids at least 3 to 4 hours a day?
7. Please tell us how satisfied you are with your hearing aids in the following situations:

- One on one conversations
Restaurants/large groups crowds
TV / Radio
In the car
In small groups
Religious services
At the movies
Hearing the doorbell
Telephone ring
Understanding on the phone

RELEASE OF INFORMATION

I give permission for release of reports, test results, and recommendations to or from my family physician, the referral source, or others as specified.

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