MAICO AUDIOLOGICAL SERVICES
Hearing Aid Evaluation History

Listening Situations Where You Need Assistance

Please check all that apply

____ Automobile	____ Talking with Children
____ Family Dinners	____ Talking with Family
____ Meetings	____ Theater
____ Movies	____ Watching Television
____ Outdoors	____ Workplace
____ Restaurants	____ Worship Services
____ Talking on the Telephone	____ Listening to Music

____ _____

____ _____

Please rank the following from 1 (most important) to 4 (least important):

Cosmetics ___ Ease of use ___ Price ___ Level of technology/sound quality ___

Please list your recreational activities (such as water sports, hunting, etc.): _____

_____

Which ear do you use on the phone? **Right** ___ **Left** ___ Do you use a **Landline** ___ and/or **Cell phone** ___?

Are you **Right-handed** ___ or **Left-handed** ___?

Do you use **Bluetooth** (wireless) devices? _____ If so, which ones? _____

Please share any other information you think might assist in understanding your situation:

_____

_____

_____

_____

- - - If you have used a hearing aid before, or are a current hearing aid user, please complete other side - - -

Questionnaire for Current Hearing Aid Wearers Only

Name: _____ Date of Completion: _____
(First) (MI) (Last)

Date of Birth: _____

How long have you been wearing hearing aid(s)? _____

How old are your present hearing aid(s)? _____

Do you wear a hearing aid in the left ear, right ear, or both? _____

Would you use a Remote Control? _____

Hearing Aid History

Does your present hearing aid. . . *Please check appropriate option*

	Always	**Occasionally**	**Seldom**	**Never**
Cause you frustration when talking with family members?	_____	_____	_____	_____
Cause you to feel "left out" when you are with a group of people?	_____	_____	_____	_____
Hamper or limit your social life?	_____	_____	_____	_____
Cause you to avoid religious services or other meetings?	_____	_____	_____	_____
Do you have ringing in your ears? (Tinnitus)	_____	_____	_____	_____

Do you experience any of the following with your current hearing aid(s) (check all that apply):

__ Some sounds are too loud
__ Sounds are too soft
__ Sound are tinny or metallic
__ Feedback or whistling
__ Naturalness of sound
__ Trouble understanding in quiet
__ Wind noise
__ Trouble using telephone
__ Changing battery
__ Difficulty adjusting volume
__ Trouble understanding in noise
__ Do not like appearance of aid
__ Do not like sound of own voice
__ Battery Life
__ Repair issues
__ Other: _____