

**Telling the Hearing Specialist about me**

**Your Name: …………………………………………………………………………**

**The name you liked to be called: ………………………………………………**

**Date of birth: ……………………………..**

**Phone number: ………………………….**

**Were you helped to complete this form? Yes No**

**If yes, please enter name, telephone number and the address of the person who helped you and how they know you.**

**…………………………………………………………………………………………..**

**............................................................................................................................**

**…………………………………………………………………………………………..**

**Things to bring to your hearing test:**

* **A completed copy of this form**
* **Your hearing aids (if you have any)**
* **Any previous hearing test reports (if you have any)**

**Please fill in as much of this form as you can. Please answer using a √ or comment.**

**MEDICAL HISTORY**

**Have you had your hearing tested before? Yes**

 **No**

**If you have, when was this? Were you told that your ears have**

**difficulty hearing?**

**………………………………………………………………………………………**

**………………………………………………………………………………………**

**………………………………………………………………………………………**

**Have you had a hearing aid before? Yes**

 **No**

**Do you sometimes find it difficult to hear? Yes**

 **No**

**Do you have problems with your balance? Yes**

 **No**

**Do you ever hear noises in your ears that Yes**

**other people cannot hear? (Tinnitus)**

 **No**

**Has anyone in your family had a hearing Yes**

**problem?**

 **No**

**Do you, or have you had ear infections? Yes**

 **No**

**Have you ever had any operations on your Yes**

**ears?**

 **No**

**Have you ever worked in, or been exposed to loud noise? If yes, what did you do?**

**............................................................................................................................**

**…………………………………………………………………………………………..**

**Do you take any medication or tablets? If yes, what?**

**…………………………………………………………………………………………**

**………………………………………………………………………………………....**

**Do you have any disabilities, diagnosis of a memory issue or other health problems? If yes, what are they?**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**………………………………………………………………………………………….**

**………………………………………………………………………………………….**

 **Are you a wheelchair user? Yes**

 **No**

**COMMUNICATION**

**How do you prefer to communicate? (Spoken word, pictures, Makaton, lip-reading, British Sign Language or other)**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**Do you speak loudly? Yes**

 **No**

**Do you speak quietly? Yes**

 **No**

**When you talk, do people Yes**

**find it easy to understand**

**you? No**

**RESPONSE TO OTHERS**

**Do you always hear when people call Yes**

**your name?**

 **No**

**Can you hear people talking to you Yes**

**when they are far away?**

 **No**

**When people are close can you hear Yes**

**them talking to you?**

 **No**

**Can you hear people better when Yes**

**you are watching their faces?**

 **No**

**RESPONSES TO THE ENVIRONMENT**

**Do you need to sit very close to the Yes**

**TV or music? Or have it turned up**

**loud to hear it well? No**

**Do you become upset by loud noises, Yes**

**for example a police siren?**

 **No**

**Do you hear the telephone ringing? Yes**

 **No**

**Can you hear people talking to you Yes**

**on the telephone?**

 **No**

**THINGS WE NEED TO KNOW ABOUT YOU**

**When you have your hearing test, the hearing specialist will need to look in your ears and do some tests to see how well you can hear**

**Will you be ok going into new places with new people?**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**Will you be ok in a waiting room with other people?**

**…………………………………………………………………………………………**

**………………………………………………………………………………………...**

**Will it be ok if the hearing specialist needs to touch your face and ears during the hearing assessment?**

**………………………………………………………………………………………….**

**………………………………………………………………………………………….**

**Will you be ok wearing headphones over your ears?**

**………………………………………………………………………………………….**

**………………………………………………………………………………………….**

**Would you consider wearing hearing aids if they could help you hear better?**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**Are you able to make your own decisions regarding your own care?**

**…………………………………………………………………………….................**

**………………………………………………………………………………………..**

**………………………………………………………………………………………..**

 **Please tell us any other information that you think might be helpful:**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**…………………………………………………………………………………………**

**If you have any questions about the appointment or would like to talk to someone before you come to your appointment then please phone us (01271) 322476.**

**We also have more information on our website:**

**[www.royaldevon.nhs.uk/audiology-northern](http://www.royaldevon.nhs.uk/audiology-northern)**