Patient Name:_______________________________________ Today's Date:__________

Last First MI

Primary concern: _______________________________ ☐ Right Ear ☐ Left Ear ☐ Both

Date Problem Began:_______________ ☐ Sudden ☐ Gradual ☐ Fluctuating

Have you ever had a hearing test before? ☐ Yes ☐ No When? ________Where? ________

Do you currently wear hearing aids? ☐ Yes ☐ No Age of Hearing Aids?_______________

Any issues with current hearing aids? _______________________________________

Have you ever experienced any of the following:

- ☐ Diabetes
- ☐ Dizziness or Balance Issues
- ☐ Ear Infections
- ☐ Ear Pain
- ☐ Ear Surgery
- ☐ Pressure in the Ears
- ☐ Family History of Hearing Loss
- ☐ Exposure to Loud Noise
- ☐ Head Trauma
- ☐ Seasonal Allergies
- ☐ Vascular or Heart Conditions
- ☐ History of High Blood Pressure
- ☐ High Stress Levels
- ☐ Anxiety or Depression
- ☐ Changes with Sleep Patterns
- ☐ Ringing or Noises in the Ears

Other Relevant Medical History: _______________________________________

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INTERNAL USE ONLY BELOW

COSI Listening Needs Assessment

1. ____
2. ____
3. ____

Otoscopy: ☐ Clear ☐ Non-Occluding Cerumen ☐ Occluding Cerumen ☐ Other:

Tympanometry: ☐ Type A ☐ Type As ☐ Type Ad ☐ Type B ☐ Type C

SRT: ______________________ WRS: ______________________

Tinnitus Pitch: ____________ Loudness: _______________ MML: ____________ THI Score: _______________