HEARING AID CENTER
CONFIDENTIAL MEMBER CASE HISTORY FORM

Name:

Costco Warehouse Name and Number: _____ Today's Date: _____

MEMBER INFORMATION

First Name: _____ M.I.: _____ Last Name: _____

Membership Number: _____ Date of Birth: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone Number: _____ Secondary Phone Number: _____

Email: _____ Spouse/Significant Other Name: _____

Occupation: _____ ☐ Retired ☐ Working

MEDICAL HISTORY

Certain types of medication can impact your hearing or may complicate taking an impression of your ear. Do you take any of the following types of medication? If so, please check the appropriate box(es) and list.

☐ Blood Thinners ☐ Heart Medications ☐ Insulin ☐ Chemotherapeutic Agents ☐ Pain Relievers

_____

_____

As part of your hearing evaluation, you may come into contact with various materials. Are you allergic to any of the following?

☐ Latex ☐ Nitrile ☐ Plastics ☐ Rubber ☐ Silicone ☐ Other _____

Have you ever had medical/surgical treatment for your ears? ☐ Yes ☐ No

If yes, at what age? _____ Type of surgery/treatment: _____

Check any of the following conditions if you currently have or have had in the past.

☐ Arthritis	☐ Diabetes I or II	☐ Meningitis	☐ Scarlet Fever
☐ Allergies	☐ Hepatitis	☐ Multiple Sclerosis	☐ Seizures
☐ Bell's Palsy	☐ High Blood Pressure	☐ Neuropathy	☐ Stroke/TIA
☐ Concussion/Skull Fracture	☐ High Fever	☐ Pacemaker	☐ Tuberculosis
☐ Depression/Anxiety	☐ HIV	☐ Parkinson's Disease	☐ Vision Problem
☐ Cancer	☐ Measles/Mumps	☐ Memory Issues	☐ Other:
Type/Treatment:	☐ Meniere's	Diagnosis:	_____
_____		_____	_____

Date:

HEARING HISTORY

☐ Yes ☐ No Have you ever had your hearing tested? If yes:

When? _____ Where? _____

Was hearing loss detected? ☐ Yes ☐ No

☐ Yes ☐ No Have you ever been fit with a custom-molded ear piece?

☐ Yes ☐ No Is your hearing better on some days compared to other days?

☐ Yes ☐ No Have you ever heard noises in your ears (e.g., buzzing, ringing, clicking, roaring)?

If yes, which ear(s)? ☐ Both ☐ Right ☐ Left Describe the sound you hear: _____

How often? _____ Is it bothersome? ☐ Yes ☐ No

☐ Yes ☐ No Have you ever been exposed to occupational or recreational noise (e.g., military, music, gunfire)?

If yes, describe: _____

☐ Yes ☐ No Does anyone in your family have hearing loss? If so, who? _____

☐ Yes ☐ No Have you seen a physician for your hearing?

If yes, what type of physician? ☐ Primary Care ☐ General Practitioner ☐ ENT ☐ Other

☐ Yes ☐ No Have you ever tried a hearing aid(s)?

If yes: Do you wear the device(s) now? ☐ Yes ☐ No

If yes, what type of hearing aid(s) do you have? _____

Check the box of the picture that looks like your hearing aid(s):

☐ OPEN FIT

☐ BEHIND THE EAR

☐ IN THE EAR

☐ IN THE CANAL

☐ COMPLETELY IN THE EAR

How long have you worn hearing aid(s)? _____

Which ear(s) do you wear the device(s) in? ☐ Both ☐ Right Only ☐ Left Only

Do you wear your hearing aid(s) regularly? ☐ Yes ☐ No

Do you hear better with your hearing aid(s)? ☐ Yes ☐ No

What do you like about your hearing aid(s)? _____

What do you dislike about your hearing aid(s)? _____

☐ Yes ☐ No Have you ever purchased and returned a hearing aid?

If yes, why did you return it? _____

Is there any other information related to your hearing that you feel may be important for us to know?

_____

_____

HEARING NEEDS ASSESSMENT

Circle the number, 1 being the worst and 10 being the best: How would you rate your overall hearing ability without hearing aids?

1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10
Worst Best

Please list the top three situations in which you would like to hear better. Be as specific as possible.
For example: I would like to hear my daughter on my cellphone when we talk every Sunday.

1. _____

2. _____

3. _____

Some things about hearing aids may seem more important than others. Please put a 1 by the most important consideration, a 2 by the next most important, a 3 by the third-most important, and a 4 by the least important.

_____ Hearing aid size and the ability of others to (not) see the hearing aids

_____ Improved ability to hear and understand speech

_____ Improved ability to understand speech in noisy situations (e.g., restaurants, parties)

_____ Cost of the hearing aids

Please choose the statement that is most true for you.

_____ I prefer my hearing aids to be automatic so that I do not have to make any adjustments to them.

_____ I prefer to adjust the volume and change the listening programs of my hearing aids as I see fit.

_____ I do not have a preference.

☐ Yes ☐ No I am interested in listening to audio from a device such as a cellphone, tablet or TV through my hearing aids.

I would like to stream from the following type of device:

☐ iPhone	☐ Android Cellphone	☐ Other Cellphone: _____
☐ iPad	☐ Android Tablet	☐ Other Tablet: _____
☐ TV	☐ Computer	☐ Other Audio Device: _____

PRIVACY NOTICE

_____
Member Initials

I have reviewed the Costco Health Center Notice of Privacy Practices (the "Notice"), and understand that all of my medical information will be used by Costco Wholesale in accordance with the Notice.

INFORMATION STATEMENT

_____
Member Initials

To provide a custom-fitted hearing aid, an accurate impression of the ear canal must be made. In some instances there may be some minor discomfort involved during the insertion of the impression material and the subsequent removal of the finished impression. Occasionally, there may also be some temporary aftereffects that might include: throbbing, abrasion to the ear canal, redness, soreness, hematoma or bleeding. Although rare, if a problem should occur, you should seek proper medical treatment.

IMPORTANT MEDICAL CONSIDERATIONS FOR A HEARING AID FITTING

To be completed by a Costco employee:

☐ Yes ☐ No Acute or chronic dizziness

☐ Yes ☐ No Pain or discomfort in the ear

☐ Yes ☐ No History of sudden or rapidly progressive hearing loss within the previous 90 days

☐ Yes ☐ No Unilateral hearing loss of sudden or recent onset within the previous 90 days

☐ Yes ☐ No History of active drainage from the ear within the previous 90 days

☐ Yes ☐ No Visible congenital or traumatic deformity of the ear

☐ Yes ☐ No Visible evidence of significant cerumen accumulation or a foreign body in the ear canal

☐ Yes ☐ No Audiometric air-bone gaps equal to or greater than 15 dB at 500, 1K, and 2K Hz

If the answer to any of the above questions is "yes," the member is advised that their best interests would be served by consulting with a licensed physician (preferably an ear specialist).

FOR STAFF ONLY

I have reviewed the Confidential Case History and Information Statements with the member.

HAC Licensed Staff Signature: _____ Date: _____

Title: _____

License #: _____

Dispenser Stamp/Sticker: