



CONFIDENTIAL MEMBER CASE HISTORY FORM

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

MEMBER INFORMATION

Given Name/s: _____ Surname: _____

Membership Number: _____ Date of Birth: _____

Street Address: _____

Suburb: _____ State/Territory: _____ Postcode: _____

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 tick 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.

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes I or II | <input type="checkbox"/> Meningitis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bell's Palsy | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Stroke/TIA |
| <input type="checkbox"/> Concussion/Skull Fracture | <input type="checkbox"/> High Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> HIV | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Vision Problem |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Measles/Mumps | <input type="checkbox"/> Memory Issues | <input type="checkbox"/> Other: |

Type/Treatment: _____ Diagnosis: _____

Name: _____

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-moulded 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?

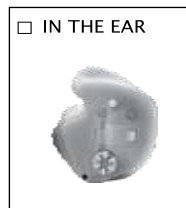
If yes, what type of physician? General Practitioner ENT Other

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? _____

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



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 mobile phone 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 mobile phone, tablet or TV through my hearing aids.

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

iPhone

Android mobile phone

Other mobile phone: _____

iPad

Android Tablet

Other Tablet: _____

TV

Computer

Other Audio Device: _____

PRIVACY NOTICE

Member
Initials

I have reviewed the Costco Health Centre 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, haematoma 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
- Yes No Sensorineural asymmetry, consisting of >20 dB at 500, 1000 or 2000 Hz and/or >30 dB at 3000, 4000 or 6000 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 Staff Signature: _____ Date: _____

Printed Name/Title: _____