HEARING HEALTH REPORT - NEW PATIENT

CLIENT HISTORY

PLEASE PRINT

Last Name _____ First Name _____ MI _____ ☐ Male ☐ Female

Address _____ City _____ State _____ Zip _____

Cell Phone ( ) _____ - _____ Home Phone ( ) _____ - _____ Work Phone ( ) _____ - ____

Date of Birth _____ - _____ - _____ ☐ Married ☐ Single ☐ Widow(er) E-mail address _____

Occupation _____ If retired, what kind of work did you do? _____

Who is with you today? _____ Relationship _____

Primary Care Physician Name _____ City _____ Phone _____

Insurance Carrier _____ I.D. No./Policy No. _____

How did you hear about us? _____ If you were referred to us, who may we thank? _____

I have received a copy of the company's Privacy Practices and understand its contents. ☐ Yes ☐ No

Permission to release test information to physician? ☐ Yes ☐ No

Permission to release test information to designated person(s) listed below? ☐ Yes ☐ No

Name(s) and relationship(s) _____

Patient's Signature _____ Date _____

MEDICAL HISTORY

Do you have any allergies? ☐ Yes ☐ No If yes, please list _____

Do you have high or low blood pressure? ☐ Yes ☐ No If yes, high or low? _____

Are you diabetic? ☐ Yes ☐ No If yes, are you insulin-dependent? ☐ Yes ☐ No

Do you have any arthritis? ☐ Yes ☐ No

Have you ever been diagnosed with cancer? ☐ Yes ☐ No If yes, please describe _____

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list _____

Are you taking any blood thinners? ☐ Yes ☐ No If yes, please list _____

Have you been examined by a doctor in the past 6 months? ☐ Yes ☐ No

Have you received any medical or surgical treatment for your hearing loss? ..... ☐ Yes ☐ No

PATIENTS: PLEASE DO NOT FILL OUT ANYTHING BELOW THIS LINE.

☐ 1. HEARING HEALTH HISTORY

Amplification History

Are you a current hearing aid wearer? ☐ Yes ☐ No Type: _____

Ear fitted: ☐ Both ☐ Left ☐ Right Vent size: _____ Previous Occlusion: ☐ Significant ☐ Slight ☐ None

If yes, and you could improve something about your current hearing aids, what would it be? _____

Do you know anyone who wears hearing aids? ☐ Yes ☐ No If yes, who? _____

General History

Do you have a family history of hearing loss? ..... ☐ Yes ☐ No

Do you have a history of noise exposure? ..... ☐ Yes ☐ No

Have you experienced any acute or chronic dizziness/vertigo/imbalance/light-headedness? ..... ☐ Yes ☐ No

When was your last hearing test? _____ What was the result or recommendation from that exam? _____

In which ear is your hearing most impaired? ..... ☐ Left ☐ Right ☐ Same

When did you first notice a decline in your hearing? Within the past... ☐ 90 days ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ 10+ years

Do you know the cause of your hearing loss? (explain) ..... ☐ Yes ☐ No

Have you noticed any change in your ability to remember? ..... ☐ Yes ☐ No

Do you have ringing in your ears? ..... ☐ Yes ☐ No

Do you sometimes hear conversation loud enough but cannot understand the words? (explain) ..... ☐ Yes ☐ No

Do you find it difficult to understand conversation in noise? (explain) ..... ☐ Yes ☐ No

Do you have trouble hearing on the telephone? ☐ Yes ☐ No ☐ Landline ☐ Cellphone (what kind?) _____

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