PATIENT INTAKE FORM

CLIENT HISTORY

PLEASE PRINT

Today's Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

Address _____ ❑ Male ❑ Female ❑ Married ❑ Single ❑ Widow(er)

City _____ State _____ Zip _____ County _____

Phone ( ) _____ - _____ E-mail address _____

Date of Birth _____ - _____ - _____ Past/Present Occupation _____

Accompanying Party or Companion _____ Relationship _____

Family Physician Name _____ City _____ Phone _____

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

Permission to release a copy of test information to physician? ❑ Yes ❑ No Patient's Signature _____

MEDICAL AND HEARING HEALTH HISTORY

Do you have any of the following:

- Deformity of the ear? ❑ Yes ❑ No
- Sudden or rapid hearing loss in the past 90 days? ❑ Yes ❑ No
- Pain or discomfort in the ear? ❑ Yes ❑ No
- Acute or recurring dizziness? ❑ Yes ❑ No
- Previous ear infections? ❑ Yes ❑ No
- Active drainage from the ear? ❑ Yes ❑ No

Have you ever found it necessary to have a doctor remove wax from your ears? ❑ Yes ❑ No

In which ear is your hearing the worst? ❑ Both ❑ Yes ❑ No

Do you have any sinus or allergy problems? ❑ Yes ❑ No If yes, please list _____

Are you a diabetic? ❑ Yes ❑ No If yes, are you insulin-dependant? _____

Have you had exposure to excessive noise? ❑ Yes ❑ No

Do you have a history of firearm use? ❑ Yes ❑ No

Which ear do you use on the telephone? ❑ Right ❑ Left

Do you have ringing or other noises in your ears? ❑ Yes ❑ No If yes, which ear? _____

Have you previously had a hearing test? ❑ Yes ❑ No If yes, by whom and when? _____

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

If yes, when? _____ Explain _____

Physician/ENT _____ City _____ Phone _____

AMPLIFICATION HISTORY

Are you a current hearing aid wearer? ❑ Yes ❑ No Type _____ Ear fitted: ❑ Both ❑ Left ❑ Right

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

_____

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