

PATIENT HISTORY

Date _____

PERSONAL

Name _____

Address _____

City _____

State _____ Zip _____

Phone

Home _____ Work _____ Cell _____

Email _____

Date of Birth _____ Age _____

Marital Status:

Single Married Divorced Widowed

Name of spouse, if applicable _____

Employment Status:

Part-Time Full-Time Retired Student

Occupation (*current or former*) _____

Insurance:

Primary Insurance Co. _____ ID# _____

Name of Policy Holder _____ Policy Holder DOB _____

MEDICAL HISTORY

Primary Care Physician _____

Phone _____

Address _____

Have you seen a physician specializing in diseases of the ear? Yes..... No

If yes, when _____ Name _____

Have you ever been treated by a physician for your hearing or ear problems? Yes..... No

If yes, describe: _____

Have you ever had any type of ear surgery? Yes..... No

If yes, describe: _____

Medical History/Conditions (*Check all that apply*)

Vision difficulty Ringing in the ears/head noises

Pacemaker Blood thinner use

Are you being treated for any of the following?

High blood pressure Thyroid problems

Diabetes

Please list:

Medications you are taking: _____

Serious illnesses/major surgeries within 10 years:

HEARING HISTORY

How long have you had hearing difficulties?

Less than a year 2-5 years 10 years+

1-2 years 5-10 years

Have you ever had a hearing test? Yes.... No

If yes, when and by whom? _____

Do you wear hearing instruments? Yes.... No

If yes, how long? _____

Which ear do you use on the phone? _____

Have you ever worked in noise? Yes.... No

If yes, describe _____

Does anyone in your family have trouble with their hearing? Yes.... No

If yes, how are you related? _____

Does your hearing cause you difficulty...

When listening to TV or radio? Yes.... No

When attending religious (or similar) functions? Yes.... No

Understanding voices in background noise? Yes.... No

When talking with your spouse or other family members? Yes.... No

When you're on the phone? Yes.... No

Please describe any other hearing/communication difficulties you are experiencing: _____

How did you hear about us?

Physician

Friend

Newspaper

Mail

You Called Me

TV/Radio

Website

Facebook

Yellow Pages

Other _____