Family
HEARING CENTER

Confidential Patient Information

Patient Name: _____ DOB: _____ Sex: M / F

Address: _____ City: _____ State: _____ Zip: _____

Home #: _____ Work #: _____ Cell #: _____

Email Address: _____ Marital Status: _____

Parent's Name (if minor): _____ Spouse's Name: _____

Emergency Contact Name: _____ Phone #: _____

How did you hear about us? _____

Are you an American Veteran? _____

Insurance Company: _____

Primary Doctor: _____ Phone #: _____

Who is financially responsible for services rendered? _____

DO YOU HAVE ANY OF THE FOLLOWING?

Acute or recurring dizziness?	▫ Yes	▫ No
Pain or swelling in your ears?	▫ Yes	▫ No
Sinus/allergy problems?	▫ Yes	▫ No
Ringing or noises in your ears?	▫ Yes	▫ No
If yes, which ear?	▫ Right	▫ Left
Family history of hearing loss?	▫ Yes	▫ No

Please explain: _____

_____

Medical History

Have you had a hearing test in the past 6 months?	▫ Yes	▫ No

When? _____ Where? _____

Have you ever had wax removed from your ears by a doctor?	▫ Yes	▫ No
Have you ever had ear infections?	▫ Yes	▫ No
Do you currently have an ear infection?	▫ Yes	▫ No
Have you had any ear drainage in the last 90 days?	▫ Yes	▫ No
Do you know the cause of your hearing loss?	▫ Yes	▫ No

Please explain: _____

_____

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Have you ever had a heart attack?	▫ Yes	▫ No
Are you taking blood thinning medication? (daily aspirin)	▫ Yes	▫ No
Do you have a pace maker?	▫ Yes	▫ No
Do you hear better out of one ear than the other?	▫ Yes	▫ No
If yes, which is the better ear?	▫ Right	▫ Left
Are you diabetic?	▫ Yes	▫ No
Have you ever had cancer?	▫ Yes	▫ No
Have you ever had chemotherapy or radiation treatments?	▫ Yes	▫ No
Do you have an allergy to latex or plastic?	▫ Yes	▫ No
Have you ever had a stroke?	▫ Yes	▫ No

HAVE YOU EVER HAD ANY OF THE FOLLOWING?
(CHECK ALL THAT APPLY)

▫ Whooping cough	▫ Measles	▫ Scarlet Fever	▫ Mumps	▫ Diphtheria
▫ Meningitis	▫ Encephalitis	▫ Chicken Pox	▫ Viral Pneumonia	

HAVE YOU EVER TAKEN THE FOLLOWING MEDICATIONS?
(CHECK ALL THAT APPLY)

▫ Quinine	▫ Streptomycin	▫ Neomycin	▫ Kanamycin

_____

_____

_____

_____

Hearing History
(WITHOUT HEARING AIDS)

Do you find yourself asking people to repeat themselves?	▫ Yes	▫ No
Do others complain that you set the TV too loud?	▫ Yes	▫ No
Do you avoid social events because of your hearing difficulty?	▫ Yes	▫ No
What is the biggest problem you experience with your hearing?		

_____

Do you have a hearing instrument?	▫ Yes	▫ No
If a hearing loss is discovered, are you ready for help?	▫ Yes	▫ No
How much do you expect to pay for new hearing devices?	_____	

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WHAT ARE YOUR HEARING PRIORITIES?
(PLEASE MARK THE MOST IMPORTANT TO YOU)

- ▫ Understanding speech better
- ▫ Size of hearing instrument
- ▫ Service after purchasing
- ▫ Performance in noisy surroundings
- ▫ Price of hearing instruments

HEARING AID EXPERIENCE:

- ▫ No experience
- ▫ Less than 6 weeks
- ▫ 6 weeks to 11 months
- ▫ 1 to 5 years
- ▫ 6 to 10 years

DAILY HEARING AID USE:

- ▫ No use
- ▫ Less than 1 hour
- ▫ 1 to 4 hours
- ▫ 5 to 8 hours
- ▫ 9 to 16 hours

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document upon my request.

Signature of Patient or Personal Representative: _____

Date: _____

Name of Patient or Personal Representative: _____

Description of Personal Representative's Authority: _____