Let's Get To Know You

About You

Contact Information

Please Print

Today's Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

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

City _____ State _____ Zip _____ County _____

Phone ( ) _____ - _____ Email Address _____

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

Accompanying Party or Companion _____ Relationship _____

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

Physician Information

Referring Physician _____

Primary Care Physician Name _____ City _____ Phone ( ) _____ - _____

(If different than listed above)

Permission to release a copy of test information to physician? ❑ Yes ❑ No

Patient's Signature _____

Where did you hear about us?

Check box(es) below

❑ Mail ❑ Website ❑ Radio ❑ Insurance

❑ Newspaper ❑ Internet Search ❑ TV

❑ Physician Referral ❑ Phone Call ❑ Health Fair

❑ Referral by Friend: _____ _____

First Name *Last Name*

Let's Get To Know You

About Your Health

Hearing Health History

Please Print

What is the primary reason you came in today? ❑ Hearing Issues ❑ Dizziness/Vertigo ❑ Tinnitus ❑ Other

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

How long have you experienced the issues described above?
❑ Less than 1 year ❑ 1–5 years ❑ 5–10 years ❑ 10+ years

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

Was your hearing loss sudden or gradual onset and in which ear?
❑ Sudden ❑ Gradual ❑ Left Ear ❑ Right Ear ❑ Same in Both Ears

Have you experienced any of the following in the last 90 days?
❑ Excessive Ear Wax ❑ Ear Draining/Bleeding ❑ Ear Pressure/Fullness ❑ Swimmer's Ear
❑ Dizziness/Vertigo ❑ Ear Pain ❑ Fluctuating Hearing Loss ❑ Popping Sensation in Ear

Have you been diagnosed with any of the following?
❑ Cholesteatoma ❑ Otosclerosis ❑ Sudden Hearing Loss
❑ Acoustic Neuroma ❑ Ossicular Dislocation ❑ Meniere's Disease

Have you been exposed to any of the following?
❑ Power Tools ❑ Hunting/Firearms ❑ Loud Music ❑ Occupational/Industry Noise

Have you ever worn a hearing aid? ❑ Yes ❑ No Type _____ Ear fitted: ❑ Both ❑ Left ❑ Right

Medical History

Have you had, or do you currently have any of the following?
❑ Cardiovascular Disease ❑ Head Injury ❑ Illness with High Fever ❑ Vision Problems
❑ High Blood Pressure ❑ Dizziness ❑ Dementia/Alzheimer's ❑ Multiple Sclerosis
❑ Pace Maker ❑ Balance Concerns ❑ Cognitive Issues ❑ Parkinson's
❑ Stroke ❑ Diabetes ❑ Depression/Anxiety ❑ Obesity
❑ Seizures ❑ Cancer ❑ Arthritis ❑ Other _____

If yes, when? _____ Explain _____

Physician/ENT _____ City _____ Phone ( ) _____ - _____

Please describe the impact, if any, these conditions have on your daily life: _____

_____

_____

Current medications: (Please list all current prescribed and over-the-counter medications): _____

_____

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