Kricket Audiology, LLC

PATIENT INFORMATION FORM

Patient Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: ___ M ___ F Marital Status: ___ S ___ M ___ W ___ D

Address: _____

_____

Phone: Home: _____ Cell: _____ Work: _____

Email: _____ SS#: _____

Occupation: _____ Employer: _____

Insurance: _____ Physician: _____

Full Name of Responsible Party if Patient is a Minor: _____

How did you hear about us? _____

Please answer the following questions:

Are you experiencing hearing loss in one ear or both ears? R _____ L _____ Both _____

Is this your first hearing test? Yes _____ No _____

Do you hear ringing or other sounds in your ears? Yes _____ No _____

Do you experience dizziness or lightheadedness? Yes _____ No _____

Have any relatives experienced hearing loss at a young age? Yes _____ No _____

Have you had surgery on one or both ears? Yes _____ No _____

Have you had any ear pain or drainage in the last 30 days? Yes _____ No _____

Have you been treated with chemotherapy? Yes _____ No _____

Have you been exposed to high levels of noise? Yes _____ No _____

Do you suffer from any serious illnesses? _____

Do you have difficulty hearing in group situations? Yes _____ No _____

Have you ever tried or worn hearing aids? Yes _____ No _____

What would you like us to help you with today? _____

_____