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:

____

____

____

When Wearing Hearing Instruments

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 ____________

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