HEALTHY HEARING NOW

Today's Date_____

Last Name _____ First Name _____ MI_____

Address_____ Zip_____

Phone _____ Email_____DOB_____

Past/Present Occupation_____ ☐ Male ☐ Female ☐ Single ☐ Married ☐ Widow(er)

Accompanying Party or Companion_____ Relationship_____

Family Physician Name_____ City_____ Phone_____

How did you hear about Healthy Hearing Now? _____

Permission to release test information to physician? ☐ Yes ☐ No Patient Signature_____

MEDICAL AND HEARING HEALTY HISTORY

Do you have any of the following:

Deformity of the ear?	☐ Yes ☐ No	Pain of discomfort in the ear?	☐ Yes ☐ No
Acute or recurring dizziness?	☐ Yes ☐ No	Sudden rapid hearing loss (last 90 days)?	☐ Yes ☐ No
Previous ear infections?	☐ Yes ☐ No	Active drainage from ear?	☐ Yes ☐ No

Have you ever found it necessary to have a doctor remove wax from your ears? ☐ Yes ☐ No

In which ear is your hearing the worse? ☐ Right ☐ Left ☐ Both

Which ear do you use on the telephone? ☐ Right ☐ Left

Do you have: ☐ Memory Loss ☐ Alzheimer's or Dementia ☐ Autoimmune Disease (ex. HIV or Lupus)

Do you have any sinus or allergy condition? ☐ Yes ☐ No If yes, please list_____

Are you a diabetic? ☐ Yes ☐ No If yes, are you insulin-dependent? _____

Have you had exposure to excessive noise? ☐ Yes ☐ No

Do you have a history of firearm use? ☐ Yes ☐ No

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

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

Have you received any medical treatment for hearing loss?

If yes, when_____ Describe treatment _____

ENT_____City_____ Phone_____

AMPLIFICATION HISTORY

Are you a current Hearing aid wearer? ☐ Yes ☐ No Type_____ Ear fitted: Both ☐ Right ☐ Left

If yes, and you could improve something about your hearing aids what would that be?_____

Do you know anyone who wears hearing aids? ☐ Yes ☐ No If yes, who?_____