



PLEASE PRINT

Today's Date _____ - _____ - _____

Last Name _____ First Name _____ MI _____

Address _____ Male Female Married Single Widow(er)

City _____ State _____ Zip _____ County _____

Phone () _____ E-mail Address _____

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

Accompanying Party or Companion _____ Relationship _____

Family Physician Name _____ City _____ Phone _____

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

Permission to release a copy of test information to physician? Yes No **Patient's Signature** _____

MEDICAL AND HEARING HEALTH HISTORY

Do you have any of the following:

- Deformity of the ear? Yes No
- Sudden rapid hearing loss in the past 90 days? Yes No
- Pain or discomfort in the ear? Yes No
- Acute or recurring dizziness? Yes No
- Previous ear infections? Yes No
- Active drainage from the 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 worst? Both Left Right

Do you have Memory Loss Alzheimers or Dementia Autoimmune Disease (e.g., HIV or Lupus)

Do you have any sinus or allergy problems? 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

Which ear do you use on the telephone? Left Right

Do you have ringing or other noises in your ears? 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 or surgical treatment for your hearing loss? Yes No

If yes, when? _____ Explain _____

Physician/ENT _____ City _____ Phone _____

AMPLIFICATION HISTORY

Are you a current hearing aid wearer? Yes No Type _____ Ear fitted: Both Left Right

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

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