

Patient Information

Today's date: ___/___/___

First Name: _____ Last Name: _____ Gender: M F

Address: _____ City: _____ State: _____ Zip: _____

DOB: ___/___/___ Age: ___ SSN: _____ Marital Status: Single Married Divorced Widowed

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Preferred Phone: Home Cell Work Email: _____

Race: _____ Ethnicity: _____ Emp Status: FT PT N/A Employer: _____

Emergency contact

Name: _____ Relationship: _____ Phone: _____

Pharmacy:

Name: _____ Address: _____ Phone: _____

Insurance Details:

Primary

Secondary

Insurance Company: _____

Name of Subscriber: _____

Relationship: _____

Policy #: _____

Group #: _____

Policy Name: _____

Referral Source

Friend/Family Google Yelp Website Physician Other _____

If Physician:

Name: _____ Phone: _____

Address: _____

Primary Care Physician

Name: _____ Phone: _____

Address: _____

Primary concern(s): _____

How or when did your problem first occur? _____

Have these concerns been previously evaluated? _____

If so, where/when? _____

I. Please check any of the following that you currently have or have had in the past:

- | | |
|---|--|
| <input type="radio"/> Pacemaker | <input type="radio"/> Family history of hearing loss |
| <input type="radio"/> Vision loss | <input type="radio"/> Head injury |
| <input type="radio"/> Peripheral neuropathy | <input type="radio"/> HIV or AIDS |
| <input type="radio"/> Diabetes | <input type="radio"/> Hepatitis |
| <input type="radio"/> High blood pressure | <input type="radio"/> Bell's palsy |
| <input type="radio"/> Heart condition | <input type="radio"/> Parkinson's disease |
| <input type="radio"/> Measles and mumps | <input type="radio"/> Stroke/TIA |
| <input type="radio"/> Meningitis | <input type="radio"/> Neurological disorders |
| <input type="radio"/> Migraines | <input type="radio"/> Ear trauma |
| <input type="radio"/> Ear infections | <input type="radio"/> Ear surgery |
| <input type="radio"/> Meniere's disease | <input type="radio"/> Tingling/numbness in face |
| <input type="radio"/> Sinusitis | <input type="radio"/> MRI or CT scan of head |
| <input type="radio"/> CMV | <input type="radio"/> Other |
| <input type="radio"/> Multiple sclerosis | |

II. Do you have any of the following symptoms? If applicable, please indicate which ear.

- Difficulty hearing: Left ear | Right ear | Both
- Ear pain: Left ear | Right ear | Both
- Ear drainage: Left ear | Right ear | Both
- Ear fullness/pressure: Left ear | Right ear | Both
- Tinnitus (noise in your ears/ head): Left Ear | Right ear | Both
- Dizziness

III. Please mark all that apply if you have difficulty hearing.

- Difficulty in quiet environments
- Difficulty in noisy environments
- Trouble understanding television
- Trouble understanding on the telephone
- Hearing loss began suddenly
- Hearing loss progressed gradually
- Fluctuations in your hearing

IV. Please answer the following questions if you experience tinnitus (noise in your ears).

Did your tinnitus begin suddenly? Yes No

Did any specific incident precipitate the onset of your tinnitus? _____

Does anything make your tinnitus better? _____

Does anything make your tinnitus worse? _____

V. Please answer the following questions if you have dizziness, vertigo, or imbalance.

Do you have dizziness/vertigo? Yes No

Does anything trigger your dizziness/vertigo? _____

Is your dizziness/vertigo constant? Yes No

Are you off balance? Yes No

Have you experienced falls? Yes No

Do you have a fear of falling? Yes No

Do you currently use an assistive device to prevent falls? Yes No

VI. Do you have a history of exposure to loud noise? Yes No

Used hearing protection? Yes No

VII. Please list all medications you are currently taking. Use back of page, if necessary.

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

Medication: _____ For: _____ Since: _____

VIII. Please list three areas you would like to address or problems you would like to improve during today's appointment.

1. _____

2. _____

3. _____

IX. Hearing aid preferences

If results show that hearing aids would be beneficial, how ready are you to try amplification?

(Please rate your readiness on this 1–10 scale.)

Not Ready • 1 • 2 • 3 • 4 • 5 • 6 • 7 • 8 • 9 • 10 • **Absolutely Ready**

Please rank these factors in order of importance (1 being important, 4 being least important):

___ Hearing in quiet ___ Hearing in noise ___ Hearing aid expense ___ Cosmetics

X. For current hearing aid users only.

Do you wear one hearing aid or two? _____ How long have you worn hearing aids? _____

Make/model _____ How old are your current hearing aids? _____

How often do you wear your hearing aids? _____

What would you want to improve about your current hearing aids?

Thank you for taking the time to provide us with this very important information about your hearing health!

Past Medical History

1. _____
2. _____
3. _____
4. _____
5. _____

Surgeries/Hospitalizations

1. _____
2. _____
3. _____
4. _____

Family History

| Relationship | Illness |
|--------------|---------|
| 1. _____ | _____ |
| 2. _____ | _____ |
| 3. _____ | _____ |
| 4. _____ | _____ |

Medication

| Name | Dosage | Frequency |
|----------|--------|-----------|
| 1. _____ | _____ | _____ |
| 2. _____ | _____ | _____ |
| 3. _____ | _____ | _____ |
| 4. _____ | _____ | _____ |
| 5. _____ | _____ | _____ |
| 6. _____ | _____ | _____ |

Allergies

- Anesthetics
- Antibiotics
- Aspirin
- Insulins
- Other: _____
- Other: _____
- Painkillers or Analgesics
- Penicillin
- Milk
- Nuts

Lifestyle

- Do you smoke? Yes No I Quit
- How many per day? _____
- Do you drink? Yes No I Quit
- How many per day? _____
- Do you use recreational drugs?

Ear Problems

- Exposure to loud noise? Yes No
- Hearing Aid? Yes No
- Difficulty Hearing Left Right Both
- Ear Pain Left Right Both
- Ear Drainage Left Right Both
- Ear Pressure Left Right Both
- Tinnitus Left Right Both
- Other: _____

I hereby authorize that payment from my medical insurance or my Medicare benefits be made to the above-named physician on any unpaid bills for services provided on or after today. I also authorize any holder of medical or other information about me to release to their health care financing, administration, its intermediaries, insurance companies, or their agents any information needed to determine benefits payable for services. I understand that I'm financially responsible for any balance not covered by my insurance carrier.

NOTICE OF HIPAA PRIVACY P01.1C t —

We are required by law to protect the privacy and confidentiality of health information about you, which we call 'Protected Health Information' or 'PHI'.

I have received this practice's Notice of Privacy Practices. The notice provides in detail the uses and disclosures of my PHI that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with my PHI. By signing below, I acknowledge that I have received a copy of the practice's privacy policies.

Signature

Name

Date