ANDERSON AUDIOLOGY

Hearing Aid Sales & Service, Inc.

Welcome to Anderson Audiology, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on both sides of this form.

How did you hear about us?_____

PERSONAL INFORMATION:

PATIENT'S NAME_____
FIRST MIDDLE LAST

MAILING ADDRESS_____
CITY STATE ZIP

911 ADDRESS IF DIFFERENT_____
CITY STATE ZIP

PHONE # (HOME): _____ (WORK/CELL)_____

DOB _____ MARITAL STATUS_____SPOUSE'S NAME_____

NAME OF PRIMARY CARE PHYSICIAN _____

NAME & PHONE # OF EMERGENCY CONTACT_____

EMAIL ADDRESS: _____May we contact you via email? YES____NO____

MEDICAL RELEASE OF RECORDS:

The undersigned herewith authorized Anderson Audiology, Hearing Aid Sales & Service, Inc. to receive and/or release medical data, medical history and/or other information to any hospital, physician, agency or person for such a release of information for the purpose of consultation, prescription or future treatment and in the interest of the proper management of my disability.

By signing below you authorize Anderson Audiology, Hearing Aid Sales & Service, Inc. to occasionally send you text messages and emails about promotions or information about our practice.

_____ _____ _____
Patient, Parent or Guardian Signature Relationship to patient Date

_____ _____
Witness Date

NAME_____ DOB_____

MEDICAL:

Do you have pain/discomfort in your ear? Yes____ No____ Right____ Left____ Both____
Have you seen a physician for this? Yes____ No____

Do you have you any drainage in your ear? Yes____ No____ Right____ Left____ Both____
Have you seen a physician for this? Yes____ No ____

Do you have a history of ear infections? Yes____ No____ Right____ Left____ Both____
Have you seen a physician for this? Yes____ No____

Do have ringing or other noises in your ear? Yes____ No____ Right____ Left____ Both____
Is it constant or intermittent? Yes____ No____
Have you seen a physician for this? Yes____ No____

Do you have dizziness or vertigo? Yes____ No____
Have you seen a physician for this? Yes____ No____

Have you ever had ear surgery? Yes____ No____ Right____ Left____ Both____
Please describe_____

MEDICAL HISTORY: (circle all that apply)

Arthritis Breathing Blood Thinner High Blood Pressure Cancer
Cholesterol Depression Anxiety Diabetes – Insulin / Pill
Gout Heart Surgery Sleeping Disorder Thyroid Wheelchair / Walker

Please describe other medical conditions we should be aware of: _____

_____

HEARING:

Do you think you have a hearing loss? Yes____ No____ Right____ Left____ Both____

Is there a family history of hearing loss? Yes____ No____ If yes, who: _____

Have you had noise exposure? Yes____ No____

If yes, from work/military/hobbies, etc., please specify _____

Have you had your hearing tested before? Yes____ No____ When_____ Results_____

Do you currently use a hearing aid? Yes____ No____ If yes, How long? _____

NOTES:
