Patient Information

Legal Name:_____DOB:____/____/____Age:_____
First initial Last

Preferred Name:_____ Gender: Male Female Marital Status: S M W

Spouse or Partner or Significant Other's Name:_____

Address:_____
Street City State Zip

Winter Address: _____
Street City State Zip

Home Telephone: (_____)_____ Cell Phone: (_____)_____
Email Address:_____

I would like to receive electronic correspondence from Ideal Hearing Solutions, including newsletters and other information. YES NO

In case of emergency, please contact: Name:_____
Relationship:_____Telephone:_____

Who is your primary physician?_____
City:_____Clinic:_____Phone: (____)_____

I authorize the release of my medical information to my physician:
Signature:_____

Who referred you to our office?

We like to know how our patient's find our office. If your physician, a family member, or a friend recommended us, we want to thank them. If you heard of us through another source, it is helpful for us to know that as well. Please indicate the MOST influential source(s) of information you have obtained about us below. If you were referred by your physician, an Audiologist, family member, or friend, we ask that you provide their name. *Circle all that apply.* Thank you!

Physician Phonebook Health Plan/HMO Audiologist
Family Member Friend Attended Seminar Internet
Newspaper Lunch&Learn Sign Other_____
If applicable, please provide the name of the person who referred you to us:_____

PRIMARY CONCERN

PLEASE CIRCLE ALL THAT APPLY

Hearing Loss Right Ear Left Ear Both Ears

Tinnitus (ringing) Right Ear Left Ear Both Ears Constant Intermittent

Other (explain)_____

_____

How long have you had these concerns?_____

_____

MEDICAL HISTORY

YES/NO Will this be your first hearing evaluation? If no, where and when was the last evaluation?_____

YES/NO Have you ever had surgery? If yes, please explain_____

_____

YES/NO Do you have a known ear condition? If yes explain:_____

_____

YES/NO Do you ever have ear pain? If yes, explain:_____

_____

YES/NO Do you ever experience dizziness/lightheadedness? If yes, explain:_____

_____

YES/NO Has a doctor ever had to remove wax from your ear?

YES/NO Is there a history of hearing loss in your family? If yes, who and cause?_____

_____

YES/NO Do you have a history of ear infections? If yes, when?_____

_____

YES/NO Do you hear better in one ear? If yes, which?_____

_____

Are you currently taking any type of blood thinners? YES / NO

Have you ever been exposed to loud noise, either currently or in the past? YES / NO

If yes, what type? *CIRCLE ALL THAT APPLY*

Farm Machinery Music Hunting/Shooting Factory Noise

Power Tools Military Jet Engines/Aircraft

Other_____

HEARING HISTORY

WITHOUT HEARING INSTRUMENTS		WITH HEARING INSTRUMENTS (IF APPLICABLE)
YES/NO	Do you find yourself asking people to repeat what they have said?	YES/NO
YES/NO	Do you have more difficulty hearing if you can't see the speaker?	YES/NO
YES/NO	Do you have more difficulty understanding in background noise?	YES/NO
YES/NO	Do others comment that the TV is too loud?	YES/NO
YES/NO	Do you hear the words without understanding them?	YES/NO

LISTENING SITUATIONS

In which situations would you like to hear better? Please circle all that apply.

One-on-one conversations Religious Services Large Groups Small Groups Workplace Car Outdoors

Telephone Meetings Movie/Theatre Restaurants TV

Other situations:_____

HEARING PREFERENCES AND EXPECTATIONS

1-Extremely Important 2-Slightly Important 3-Neutral 4-Not important

Please circle your answer

Hearing in Quiet:	1	2	3	4
Hearing in Noise:	1	2	3	4
Cost of Instrument:	1	2	3	4
Cosmetic Appearance:	1	2	3	4

1- Very 2-Somewhat 3-A little 4- Not at all

Please circle your answer below

How much benefit do you expect to gain from hearing instruments?	1	2	3	4
How motivated are you to wear hearing instruments?	1	2	3	4
How confident are you that you will be successful with hearing instruments?	1	2	3	4

HEARING INSTRUMENT PREFERENCES

Would you prefer hearing instruments that:

- ☐ Automatically adjust to different listening environments and have no manual controls.
- ☐ Allow you to manually adjust the volume and make program selections.
- ☐ Not sure or would like more information.

If the results of your hearing assessment show that hearing instruments would be beneficial, are you ready to move forward?

Please rate your readiness on this 1-10 scale by circling one number below:

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

CURRENT HEARING INSTRUMENT USERS

How long have you worn hearing instruments?_____Do you wear one or two?_____

How old are your current hearing instruments?_____How often do you wear them?_____What do you like about your current hearing instruments?_____What areas would you like to see improvement?_____

THANK YOU SO MUCH!