PATIENT INTAKE FORM

Personal Information

Date:___________________

Name:____ Date of Birth:__________________

Address:____

City:_____________________________________ State:____________ Zip Code:________________

Telephone:(H)_________________________________(C)_____________________________________

(W)______________________________ Email:__________________________________

Male______ Female______ Married______ Single_____ Occupation_____________________________

Referred to this office by____

Audiologic History

Do you have a family history of hearing loss?	Yes ________ No ________
Do you have any sinus or allergy problem?	Yes ________No ________
Do you have any tinnitus (ringing, buzzing, hissing)?	Yes ________ No ________
Do you have chronic ear pain/drainage?	Yes ________ No ________
Are you experiencing dizziness?	Yes ________ No ________
Are you currently taking any blood thinners?	Yes ________ No ________
Are you a diabetic?	Yes ________No ________
Has your hearing changed suddenly?	Yes ________ No ________
Have you ever been diagnosed with hearing loss?	Yes ________ No ________
Have you had exposure to excessive noise?	Yes ________ No ________
Have you received any medical/surgical treatment for hearing loss?	Yes ________ No ________

If yes, when?_____________ Explain____

____

Which ear do you have difficulty hearing? Right ______ Left _______ Both _______ Not Sure _______

Have you previously had a hearing test? Yes ________ No ________

If yes, by whom and when?____

Do you currently wear/own hearing aids? Yes ________ No ________

If yes, Make & Model, How long?____