

Affordable Hearing

Professional Care at Affordable Prices

CONFIDENTIAL PATIENT INFORMATION

Please complete the following form pertaining to your hearing:

CELL PHONE _____

WK. PHONE _____

PATIENT _____ PHONE _____

ADDRESS _____ DATE OF BIRTH _____

CITY _____ STATE OR PROVINCE _____ ZIP OR POSTAL CODE _____

PRESENT _____ or PREVIOUS _____ OCCUPATION: _____

PHYSICIAN'S NAME: _____

MARITAL STATUS: Single Widowed Married Name of Spouse _____

Please complete the following questions:

MEDICAL HISTORY:

Have you seen a doctor in the past six months? Yes No

Have you seen a doctor specializing in diseases of the ear? Yes No

If yes, give date _____

Have you ever had your hearing tested? Yes No

If yes, give date _____ By whom _____

Have you ever had any type of ear surgery? Yes No

If yes, type of surgery _____ Dr. _____

ABOUT YOUR EARS:

Do you have any of these symptoms?

Deformity of the ear Yes No

Drainage from either ear Yes No

Sudden or rapid loss of hearing in the past 90 days Yes No

Sudden or long-term dizziness Yes No

Hearing loss in one ear in the last 90 days Yes No

Which is your poorer ear? Right Left Same

Have you ever seen a doctor for wax removal? Yes No

Do you ever have pain in your ears? Yes No

ABOUT YOUR HEARING:

Do you experience difficulty with the following?

Understanding all the words in conversation clearly Yes No

Hearing in a crowd or in other situations where background noise is present Yes No

Hearing by telephone Yes No

How long have you had a hearing problem? _____

Does anyone else in your family have a hearing problem? Yes No

What relationship? _____

Do you now or have you ever worn a hearing aid? Yes No

If yes, brand name _____

Do you think your hearing problem can be helped? Yes No

If yes, how do you think you may be helped? _____

In what circumstances does your hearing problem give you the most trouble? _____

Who referred you to us? _____

Signature _____ Date _____

Specialist in Scientific Fitting and Servicing of Hearing Instruments