Date: ____________________ Telephone Number: ____________________

Name: ____________________ Date of Birth ____/____/____

Address: ____
Street City, St, Zip

Accompanying Party: ____________________ Relationship: ____________________

Primary Care Physician: ____________________ Address: ____________________

Email address: ____________________ Insurance: Yes / No ____________

Who encouraged you to visit our clinic today? ____________________

What have you noticed about your hearing or communication lately? ____________________

How long have you been experiencing this? ____________________

What have others noticed? ____________________

Have you ever had your hearing tested before? ____________ By whom? ____________

Results of Hearing Exam? ____________________

Do you have a history of ear infections? ____________________

Do you hear people talking but don't understand? ____________________

Do you ask people to repeat things? ____________________

Do you have ringing or noises in your ears? ________ Please describe ____________________

Do you ever experience fatigue because you are straining to hear? ____________________

Have you been exposed to loud noises? (Guns, Industrial, Military, Music)? ____________________

Are you currently on any medications? ____________________

Is there any history of Diabetes in your immediate family? ______ Type: ____________________

For Office Use Only

What are you experiencing when/in?

Crowds	TV	Restaurant	Car	Outdoors/Wind
House of Worship	Women	Children	Movies	Other

On Phone Which ear do you use on the phone? (R or L)

Remarks: ____

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