PATIENT HISTORY

Today's Date ___________

PERSONAL

Name____

Gender: ☐ Male ☐ Female ☐ Other ___________

Date of Birth ___________

Address ______________________________________

City ____

State __________________ Zip _____________

Phone: Home ______________ Cell ________________

Email ____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of spouse, if applicable _________________

Employment Status:

☐ Part-Time ☐ Full-Time ☐ Retired ☐ Student

Occupation *(current or former)* ____________________

Guardian Name ____________________________

(If applicable)

Do guardian and patient have same phone number?

☐ Yes ☐ No, please list _________________________

Primary Insurance:

Primary Insurance Co. ______________ ID# ______________

Name of Policy Holder ______________ Policy Holder DOB ______________

Secondary Insurance:

Primary Insurance Co. ______________ ID# ______________

Name of Policy Holder ______________ Policy Holder DOB ______________

MEDICAL HISTORY

Primary Care Physician ________________________

Phone _______________________________________

Address ______________________________________

Have you seen a physician specializing in diseases of the ear?............................☐ Yes......☐ No

If yes, when______ Name ___________________

Have you ever been treated by a physician for your hearing or ear problems?...........☐ Yes......☐ No

If yes, describe: _______________________________

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

If yes, describe: _______________________________

Medical History/Conditions *(Check all that apply)*

☐ Vision difficulty ☐ Ringing in the ears/head noises

☐ Pacemaker ☐ Blood thinner use

Are you being treated for any of the following?

☐ High blood pressure ☐ Thyroid problems

☐ Diabetes

Please list:

Medications you are taking:___________________

____

Serious illnesses/major surgeries within 10 years:

____

____

____

HEARING HISTORY

How long have you had hearing difficulties?

☐ Less than a year ☐ 2-5 years ☐ 10 years+

☐ 1-2 years ☐ 5-10 years

Have you ever had a hearing test? .....☐ Yes....☐ No

If yes, when and by whom? ___________________

Do you wear hearing instruments? ....☐ Yes....☐ No

If yes, how long? ____________________________

Which ear do you use on the phone? ____________

Have you ever worked in noise? ....☐ Yes....☐ No

If yes, describe ______________________________

Does anyone in your family have trouble with their hearing?................................☐ Yes....☐ No

If yes, how are you related? ___________________

Does your hearing cause you difficulty...

When listening to TV or radio? ....☐ Yes....☐ No

When attending religious (or similar) functions?...........................☐ Yes....☐ No

Understanding voices in background noise?...............................☐ Yes....☐ No

When talking with your spouse or other family members? ....☐ Yes....☐ No

When you're on the phone? ....☐ Yes....☐ No

Please describe any other hearing/communication difficulties you are experiencing: ______________

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