

Tri-City Hearing

PATIENT INFORMATION

Patient's Name: _____ Date: _____

Gender Male Female Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ Past Present

Insurance Carrier: _____ I.D. No./Policy No. _____

Marital Status Single Married Widowed Name of Spouse: _____

Name of Observing Party/Appointment Companion (if any): _____ Relationship: _____

Name of Family Physician: _____

Permission to Release a copy of test to Physician upon request? Yes No

HEARING HEALTH HISTORY

Do you have any sinus/allergy problems? Yes No If yes, please list _____

Are you a diabetic? Yes No

Do you have a history of noise exposure? Yes No

Do you have any ringing in yours ears? Yes No Left Right Both

Do you have any dizziness or loss of balance? Yes No If yes, which?

Do you have a family history of hearing loss? Yes No

Are you currently taking any medication? Yes No If yes, please list

Have you previously had a hearing test? Yes No If yes, by whom? _____ Date: _____

Have you received any medical or surgical treatment for a hearing loss? Yes No

If yes, what? _____ When? _____ Physician/ENT: _____

Any other medical condition(s)? _____

AMPLIFICATION HISTORY

Do you currently wear hearing aids? Yes No Type: _____ Ear fitted Both Left Right

If yes, what would you like to improve about your current hearing instruments? _____

LIFESTYLE

Please check all that apply: Listening to Music or Audiobooks: Eating out often Hunting Watching TV/Movies

Attending Meetings/Conferences Participating in Sports (please list): _____

Attending sporting events (please list): _____ Other: _____

How did you hear about us? Mail Phone Newspaper Yellow Pages Television Web Physician

Patient Referral (their name): _____ Other: _____