Confidential Patient Record

Date ____/____/____ Phone ( ) _____ - _____

Name _____ ☐ Male ☐ Female
Last First Initial

Address _____
Street City State Zip

☐Married ☐Single ☐Widow(er) How did you hear about us? _____
Name Relationship

Date of Birth_____/_____/_____ Email: _____

Family Physician Name _____ Phone _____

Address _____
Street City State Zip

Type of Health Insurance_____

Have you ever had a professional hearing test? _____

If so, when and where was your most recent exam? _____

Was there anything recommended as a result of this exam? _____

Amplification History

Current Hearing Aid wearer: ☐ Yes ☐ No Type_____

If yes, and you could improve 2-3 things about your current hearing instrument, what would they be? _____

Medical History

Do you have any allergies? ☐ Yes ☐ No
Do you have arthritis? ☐ Yes ☐ No
Please list medications:

Are you an insulin-dependent diabetic? ☐ Yes ☐ No
Are you currently taking any medications? ☐ Yes ☐ No
Do you have **RINGING** in the ears? (tinnitus) ☐ Yes ☐No

Have you ever received any medical or surgical treatment for a hearing loss: ☐ Yes ☐ No

If yes, when? _____ Physician/ENT:_____ Phone: _____

Address _____
Street City State Zip

Additional Information about treatment:_____

How bad do you think your hearing is?

(Hear Nothing) 1 2 3 4 5 6 7 8 9 10 (Hear Everything)

How IMPORTANT do you think it is to fix it? _____

(Fix it Now) 1 2 3 4 5 6 7 8 9 10 (Not Important)