

PATIENT HISTORY



**Hearing, Balance
& Speech Center**

Date _____

PERSONAL	Name _____	Marital Status:
	Address _____	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
	City _____	Name of spouse, if applicable _____
	State _____ Zip _____	Employment Status:
	Phone	<input type="checkbox"/> Part-Time <input type="checkbox"/> Full-Time <input type="checkbox"/> Retired <input type="checkbox"/> Student
	Home _____ Work _____ Cell _____	Occupation (<i>current or former</i>) _____
Email _____	Insurance:	
Date of Birth _____ Age _____	Primary Insurance Co. _____ ID# _____	
	Name of Policy Holder _____ Policy Holder DOB _____	

MEDICAL HISTORY	Primary Care Physician _____	Medical History/Conditions (<i>Check all that apply</i>)
	Phone _____	<input type="checkbox"/> Vision difficulty <input type="checkbox"/> Ringing in the ears/head noises
	Address _____	<input type="checkbox"/> Pacemaker <input type="checkbox"/> Blood thinner use
	Have you seen a physician specializing in diseases of the ear? <input type="checkbox"/> Yes..... <input type="checkbox"/> No	Are you being treated for any of the following?
	If yes, when _____ Name _____	<input type="checkbox"/> High blood pressure <input type="checkbox"/> Thyroid problems
	Have you ever been treated by a physician for your hearing or ear problems? <input type="checkbox"/> Yes..... <input type="checkbox"/> No	<input type="checkbox"/> Diabetes
If yes, describe: _____	Please list:	
Have you ever had any type of ear surgery? <input type="checkbox"/> Yes..... <input type="checkbox"/> No	Medications you are taking: _____	
If yes, describe: _____	_____	
	Serious illnesses/major surgeries within 10 years:	

HEARING HISTORY	How long have you had hearing difficulties?	Does your hearing cause you difficulty...
	<input type="checkbox"/> Less than a year <input type="checkbox"/> 2-5 years <input type="checkbox"/> 10 years+	When listening to TV or radio? <input type="checkbox"/> Yes.... <input type="checkbox"/> No
	<input type="checkbox"/> 1-2 years <input type="checkbox"/> 5-10 years	When attending religious (or similar) functions? <input type="checkbox"/> Yes.... <input type="checkbox"/> No
	Have you ever had a hearing test? <input type="checkbox"/> Yes.... <input type="checkbox"/> No	Understanding voices in background noise? <input type="checkbox"/> Yes.... <input type="checkbox"/> No
	If yes, when and by whom? _____	When talking with your spouse or other family members? <input type="checkbox"/> Yes.... <input type="checkbox"/> No
	Do you wear hearing instruments? <input type="checkbox"/> Yes.... <input type="checkbox"/> No	When you're on the phone? <input type="checkbox"/> Yes.... <input type="checkbox"/> No
	If yes, how long? _____	Please describe any other hearing/communication difficulties you are experiencing: _____
	Which ear do you use on the phone? _____	_____
	Have you ever worked in noise? <input type="checkbox"/> Yes.... <input type="checkbox"/> No	_____
	If yes, describe _____	
Does anyone in your family have trouble with their hearing? <input type="checkbox"/> Yes.... <input type="checkbox"/> No		
If yes, how are you related? _____		

- How did you hear about us?**
- | | | | | | |
|------------------------------------|-----------------------------------|---------------------------------------|--------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Physician | <input type="checkbox"/> Friend | <input type="checkbox"/> Newspaper | <input type="checkbox"/> Mail | <input type="checkbox"/> You Called Me | <input type="checkbox"/> TV/Radio |
| <input type="checkbox"/> Website | <input type="checkbox"/> Facebook | <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Other _____ | | |