PATIENT HISTORY

Date ______________

Hearing, Balance & Speech Center

PERSONAL

Name ______________

Address ______________

City ______________

State ______________ Zip ______________

Phone

Home ______ Work ______ Cell ______

Email ______________

Date of Birth ______________ Age ______________

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of spouse, if applicable ______________

Employment Status:
☐ Part-Time ☐ Full-Time ☐ Retired ☐ Student

Occupation *(current or former)* ______________

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: ______________

How did you hear about us?

☐ Physician ☐ Friend ☐ Newspaper ☐ Mail ☐ You Called Me ☐ TV/Radio
☐ Website ☐ Facebook ☐ Yellow Pages ☐ Other ______________