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- 2. Complete form
- 3. Email to care@HearingDoctors.com or bring printed copy to your appointment

## **HEARING HEALTH REPORT**

**CONFIDENTIAL PATIENT INFORMATION** 

1 Patient Information						
Name:			Date:			
Address:			DOB:	Age:		
City:		_	State:	Zip:		
Home Phone: Cell Phone:		Email: _				
Gender: Occupation:						
Marital Status: Single Widowed Married Divorced Name of Spouse:						
Primary Insurance:	Insured Name:		DOB:			
Primary Insurance ID#:	Primary Insurance Group #:					
Secondary Insurance: Insured N		_ Insured Name:		DOB:		
Secondary Insurance ID#:		Secondary Insurance Group #:				
,			Reviews Other:_	Community Event		
2 Basic Medical History						
Do you have a <b>Deformity of the Ear</b> ?  If yes, please describe it:	Yes	No				
Have you ever had <b>Ear Surgery</b> ?  If yes, when and where was it performed?	Yes	No				
Have you ever had <b>Diseases of the Ear</b> ?  If yes, when and where was it treated?:	Yes	No				
Have you ever had <b>Earwax Removal</b> ?  If yes, when and where was the last time?	Yes	No				
Have you ever had your <b>Hearing Tested</b> ?  If yes, when and where was the last time?	Yes	No				
Do you have High Blood Pressure? Do you have High Cholesterol? Do you have Cardiovascular Disease? Have you ever had a Heart Attack or Stroke? Do you have Diabetes/Pre-Diabetes? Do you have Memory Loss/Alzheimer's? Are you taking Blood Thinners? Do you wear a Pacemaker?	Yes Yes Yes Yes Yes Yes Yes Yes Yes	No Borderline No Borderline No No No No No No No				
How many <b>Prescription Drugs</b> do you take daily?		Please List:				



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## 3 Hearing & Balance

3 Hearing & Datance					
Have you recently experienced any of the follow	ving?				
<b>Tinnitus</b> (Ringing, Buzzing or Whooshing Sounds)	Currently	In Last 90 Days	No		
Pain in Your Ears	Currently	In Last 90 Days	No		
Sudden or Rapid Hearing Loss	Currently	In Last 90 Days	No		
Hearing Loss in one Ear	Currently	In Last 90 Days	No		
Drainage from Either Ear	Currently	In Last 90 Days	No		
Dizziness or Vertigo	Currently	In Last 90 Days	No		
Lightheadedness or Motion Sickness	Currently	In Last 90 Days	No		
Fallen or Lost Your Balance	Currently	In Last 90 Days	No		
Migraines or Vision Disturbances	Currently	In Last 90 Days	No		
Have you ever worked in, or been exposed to, excessive noise? Yes No If yes, where?					
Which ear do you struggle with most?	Right	Left Same in Bot	h Ears		
Is there family history of hearing loss?	Yes	No If yes, what re	lation?		
In what environment(s) does your hearing problem give you the most trouble:					
On a scale of 1 to 10 (1 = Not Important, 10 = Very Important):					
How important is it <b>to you</b> to solve your hearing problem?					
How important is it to your close family that you solve your hearing problem?					
How important is it <b>to your friends or colleagues</b> that you solve your hearing problem?					
4 Hearing Loss Impact					

4 Hearing Loss Impact				
<ol> <li>Answer No, Sometimes or Yes for each question.</li> <li>Do not skip a question if you avoid a situation because of a hearing problem.</li> <li>If you use a hearing aid, please answer according to the way you hear with the aid.</li> </ol>	No	Sometimes	Yes	
Does a hearing problem cause you to feel embarrassed when you meet new people?				
Does a hearing problem cause you to feel frustrated when talking to members of your family?				
Do you have difficulty hearing/understanding co-workers, clients or customers?				
Do you feel handicapped by a hearing problem?				
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?				
Does a hearing problem cause you difficulty in the movies or in the theater?				
Does a hearing problem cause you to have arguments with family members?				
Does a hearing problem cause you difficulty when listening to TV or radio?				
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?				
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?				
FOR STAFF USE: Subtotal:				



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5 Hearing Aid Experience			
Which statement describes you best?  I have a hearing aid and use it regularly in my:   I have a hearing aid, but don't use it, or use it only occ I have tried a hearing aid, but returned it. I have never used a hearing aid.	-		
6 Release & Authorization			
☐ I give Hearing Doctors permission to release my test information and provide status updates to my primary care or referring physician.			
Physician Name:	Phone Number:		
☐ I allow Hearing Doctors to release all medical information to my insurance carrier(s). I agree to accept financial responsibility for all charges which are not covered by my insurance carrier(s) for services rendered by Hearing Doctors. This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in me being financially responsible for payment in full at the time of visit.			
Signature of Patient or Guarantor:			