HearingDoctors
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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 ◯ Married ◯ Widowed ◯ Divorced Name of Spouse: _____

Primary Insurance: _____ Insured Name: _____ DOB: _____

Primary Insurance ID#: _____ Primary Insurance Group #: _____

Secondary Insurance: _____ Insured Name: _____ DOB: _____

Secondary Insurance ID#: _____ Secondary Insurance Group #: _____

How did you hear about us? ◯ Patient ◯ Internet ◯ Direct Mail ◯ Read Reviews ◯ Community Event
◯ Physician Referral ◯ Insurance Company ◯ Other: _____

2 Basic Medical History

Do you have a **Deformity of the Ear**? ◯ No ◯ Yes
If yes, please describe it: _____

Have you ever had **Ear Surgery**? ◯ No ◯ Yes
If yes, when and where was it performed?: _____

Have you ever had **Diseases of the Ear**? ◯ No ◯ Yes
If yes, when and where was it treated?: _____

Have you ever had **Earwax Removal**? ◯ No ◯ Yes
If yes, when and where was the last time?: _____

Have you ever had your **Hearing Tested**? ◯ No ◯ Yes
If yes, when and where was the last time?: _____

Do you have **High Blood Pressure**?	◯ No	◯ Yes	◯ Borderline
Do you have **High Cholesterol**?	◯ No	◯ Yes	◯ Borderline
Do you have **Cardiovascular Disease**?	◯ No	◯ Yes	
Have you ever had a **Heart Attack or Stroke**?	◯ No	◯ Yes	
Do you have **Diabetes/Pre-Diabetes**?	◯ No	◯ Yes	
Do you have **Memory Loss/Alzheimer's**?	◯ No	◯ Yes	
Are you taking **Blood Thinners**?	◯ No	◯ Yes	
Do you wear a **Pacemaker**?	◯ No	◯ Yes	

How many **Prescription Drugs** do you take daily? _____ Please List: _____

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3 About Your Hearing

Have you recently experienced any of the following?

Tinnitus (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
Fallen or Lost Your Balance	◯ Currently	◯ In Last 90 Days	◯ No

Have you ever worked in, or been exposed to, excessive noise? ◯ No ◯ Yes If yes, where?_____

Which ear do you struggle with most? ◯ Right ◯ Left ◯ Same in Both Ears

Is there family history of hearing loss? ◯ No ◯ Yes If yes, what relation? _____

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 **to you** to solve your hearing problem?

How important is it **to your close family** that you solve your hearing problem?

How important is it **to your friends or colleagues** that you solve your hearing problem?_____

4 Hearing Aid Experience

Which statement describes you best?

◯ I have a hearing aid and use it regularly in my: ☐ Right ear ☐ Left ear
◯ I have a hearing aid, but don't use it, or use it only occasionally.
◯ I have tried a hearing aid, but returned it.
◯ I have never used a hearing aid.

5 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:

_____ Date: _____