



PATIENT INTAKE FORM

Patient Information

Name _____

Birth Date _____ Age _____ Sex: Male / Female

Address _____

City _____ State _____ Zip _____ Email address _____

Home Phone _____ Work _____ Cell _____

Occupation/Retirement of: _____

Name of Accompanying Party _____ Relationship _____

Referred By

We would like to know how our patients find us.

Please check the MOST influential sources of information about this practice:

Invitation in mail Physician Family or Friend Internet Yellow Pages

Seminar Insurance Other _____

Name of referral (if applicable) _____

Insurance

Do you have Medicare? Yes No Do you have Medicaid? Yes No

Insurance carrier _____

Member ID _____ Group# _____

Primary Care Physician (PCP) _____

Address _____

Phone _____

Can we send a copy of your hearing test results to your physician? Yes No

Medical History Information

- Do you have a history of ear infections? Yes No as a Child as an Adult
- Is there a history of hearing loss in your family? Yes No If so, who? _____
- Have you received prior hearing care? Yes No
- Name/location of previous Hearing Professional _____
- Do you have tubes in your ears? Yes No
- When was your last hearing test completed? _____
- Was your hearing loss sudden? Yes No

Please describe any ear related medical history:

- | | | | | |
|---------------------------|------------------------------------|-----------------------------------|------------------------------------|------------------------------|
| Ear wax build-up | <input type="checkbox"/> Right ear | <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears | <input type="checkbox"/> N/A |
| Fullness of ear | <input type="checkbox"/> Right ear | <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears | <input type="checkbox"/> N/A |
| Drainage in your ear | <input type="checkbox"/> Right ear | <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears | <input type="checkbox"/> N/A |
| Earaches/Pain | <input type="checkbox"/> Right ear | <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears | <input type="checkbox"/> N/A |
| History of ear infections | <input type="checkbox"/> Right ear | <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears | <input type="checkbox"/> N/A |
| Previous ear surgery | <input type="checkbox"/> Right ear | <input type="checkbox"/> Left ear | <input type="checkbox"/> Both ears | <input type="checkbox"/> N/A |
- Have you seen your physician regarding any of the above? Yes No

On a scale of 1 - 10, how would you rate your overall hearing ability?

WORST 1 2 3 4 5 6 7 8 9 10 **BEST**

On a scale of 1 - 10, how important is it for you to improve your hearing right now?

NOT AT ALL 1 2 3 4 5 6 7 8 9 10 **VERY IMPORTANT**

Please answer the following regarding hearing aids:

- Have you ever worn hearing aids? Yes No
- Which ear was/is aided? Right ear Left ear Both ears
- How long have you been using hearing aids? _____
- Are you satisfied with your current aids? Yes No

Hearing Needs Assessment

Please indicate any concerns you have. Check all that apply:

- Hearing Loss: Right Ear Left Ear Both
 Difficulty Hearing: In Quiet In Noise Both
 Difficulty understanding soft speech
 Tinnitus/Ringing or Buzzing in your ears
 Dizziness

Please rate your hearing in the following situations:

SITUATION	HOW OFTEN I AM IN SITUATION		HOW WELL I CAN HEAR		
Telephone	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
Meetings	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
Workplace	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
House of Worship	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
Television	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
Car	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
Restaurant	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
Large Social Settings	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well
Quiet Room	<input type="checkbox"/> Rarely	<input type="checkbox"/> Often	<input type="checkbox"/> Poor	<input type="checkbox"/> Fair	<input type="checkbox"/> Well

How long have you noticed this difficulty? _____

Is the difficulty due to a work-related injury/exposure? Yes No

If so, date of injury: _____ Explain _____

Do you feel your hearing is changing? Yes No Is this change: Gradual Sudden

Have you been exposed to loud noise, either recently or in the past? Yes No

- Farm Machinery Power Tools Music Military
 Hunting/Shooting Jet Engines Factory Noise Other _____

Hearing Needs Assessment

Please rank the following in order of importance (1-4 with 1 being most important and 4 being least important), if a hearing aid is recommended for you (circle one):

Sound Quality and Clarity	1	2	3	4
Durability and Reliability	1	2	3	4
Cost	1	2	3	4
Appearance	1	2	3	4

What is your hearing aid(s) experience?

- I have a hearing device(s) and regularly use them in my Right Ear Left Ear
- I have a hearing device(s), but: Do not use them Use them occasionally
- I tried a hearing device(s), but did not like it.
- I have inquired about a hearing device(s) in the past, but did not purchase.
- I have never used a hearing device(s).

Please check the statement that best describes your thoughts:

- I think I hear well; however, I would like to have a baseline hearing test.
- I think I may have some hearing loss, and I am interested in finding out how it can be improved.
- I know I have hearing loss, and I am ready to purchase hearing aids in order to improve the quality of my life and of my friends and family.

Patient Signature _____ Date _____