PATIENT INFORMATION- ADULT

Last Name__________________First Name______________________ M.I._____

Sex: M F Marital Status: S M D W P DOB_______ Age____

Home Address____

____

City State Zip Code

Home # __________________________ Work/Cell # _______________________

Occupation________________________ Primary Care Physician______________

E-mail ____________________________ opt-out ☐

Referral Source: **Letter** **Newspaper** **Internet/Website**

M.D.__________ **Friend** __________ **Insurance** **Other** _________

NOTIFY IN CASE OF EMERGENCY:

Name___________________ Phone # __________________

Have you ever had radiation therapy to the head or neck?			Yes	No
Do you have a bleeding disorder? (hemophilia A/B, Von Willebrand, etc)			Yes	No
Do you have uncontrolled or insulin dependent diabetes?			Yes	No
Are you currently taking any blood thinners or Aspirin?			Yes	No
Do you have a family history of hearing loss?			Yes	No
Do you have a history of trauma to the head?			Yes	No
Do you have dizziness, vertigo, or loss of balance?			Yes	No
Do you have chronic ear pain/drainage?			Yes	No
Do you have any tinnitus (ringing, buzzing, hissing)?			Yes	No
Do you have any history of noise exposure?			Yes	No
Have you ever had surgery on your ears?			Yes	No
Have you had cerumen (wax) removal in the past ?			Yes	No
Do you have difficulty hearing?		Not sure	Yes	No
Which Ear?	Right	Left	Both	Not Sure

Briefly describe the problem ______________________________________

The problem was: Sudden Gradual

Have you had your hearing tested before? Yes No

Where/When____

Do you currently own/wear hearing aids? Yes No

Where/When did you purchase them?__________________________________