Adrian hearing center

1103 W. Beecher Street, Adrian MI 49221 517.662.3111

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____

Gender: MALE FEMALE OTHER

Marital Status: Single Married Partner Widowed Name of Spouse_____

Address _____

City_____ State_____ Zip_____

Phone (Home) _____Phone (Cell) _____

Android IPhone

E-mail_____

Occupation _____

Insurance Carrier_____ Insurance Holder_____Date of Birth_____

Name of Family Physician_____

Permission to release a copy of test information to your Family Physician Yes No

How did you hear about us? Mail Newspaper Web Physician Patient_____ Friend _____

HEALTH HISTORY

Do you have any allergies? Yes No If yes, please list _____

Are you diabetic? Yes No

Are you currently taking medications? Yes No If yes, please list (including dosage & frequency) _____

_____

Do you have arthritis? Yes No

Do you have ringing in your ear(s)? Left Right Both None If yes, describe: _____

_____

Have you previously had a hearing test? Yes No If yes, by whom?_____ Date_____

Have you received any medical or surgical treatment for hearing loss? Yes No If yes, please explain:

_____

Have you used a tobacco product (cigarette, cigar, pipe, smokeless tobacco etc.) one or more times in the last 24 months? Yes No If yes, what type(s) of products have you used?_____

Have you ever been diagnosed with depressive disorder? Yes No

Do you have any concerns regarding memory loss? Yes No

Do you have a history of ear infections? Yes No

Have you ever had a physician remove wax from your ear(s)? Yes No

Have you ever been diagnosed with a heart condition? Yes No

Any history of or active drainage from the ear within the previous 90 days? Yes No

Any history of sudden or rapidly progressive hearing loss with the previous 90 days? Yes No

Have you experienced any acute or chronic dizziness? Yes No

Is there a unilateral hearing loss of sudden or recent onset with the previous 90 days? Yes No

Have you experienced any pain or discomfort? Yes No

Family history of hearing loss? Yes No If yes, please explain_____

_____

History of noise exposure? Yes No If yes, please explain_____

_____

COMMUNICATION ASSESSMENT

Who encouraged you to come in today to see a hearing professional?_____

What have others said or noticed about your hearing/understanding or communication ability?_____

_____

How long have you noticed changes in your hearing ? _____

What would you most like to improve about your communication ability?_____

_____

What is it about **NOW** that made you decide to come here today?_____

_____

What are some environments or situations where hearing and communication could be improved for you?

_____

If I can help you hear and communicate more effectively, is that the **RESULT** you are looking for? _____

_____

Please list listening situations where communication is most important to you:

1)_____

2)_____

3)_____

Patient Signature_____Date_____