Referral:_____

Patient Information

Date:_____

Name:_____ D.O.B._____ Age:_____

Address:_____ City/State/Zip_____

Home Phone:_____ Cell Phone:_____

Work Phone: _____ Email address:_____

Occupation:_____

Name of spouse/significant other (if any)_____

Contact Person:_____ Phone #:_____

Primary Care Doctor:_____ Address:_____

Phone #: _____

Primary / Secondary Insurance (name/number):_____

PLEASE HAVE A MEDICATION LIST

Do you think/know you have a hearing loss?	Yes / No	
Have you ever had your hearing tested?	Yes / No	When?_____
Do you have tinnitus/ringing in your ears?	Yes / No	
Have you ever had ANY surgery /trauma to head or neck ?	Yes / No	Describe_____
Have you ever been exposed to loud noises?	Yes/ No	Describe_____
Do you experience any acute or chronic dizziness?	Yes / No	
Do you or have you ever worn hearing aids?	Yes / No	
Do you have a family history hearing loss?	Yes / No	
Do you take any Aspirin or blood thinners ?	Yes / No	
Do you have a heart condition?	Yes / No	Pacemaker ?_____

PLEASE CHECK ALL THAT APPLY

_____ Stroke	_____ Arthritis	_____ High Blood Pressure
_____ Memory Loss	_____ Vision Problems	_____ Cancer
_____ Neuropathy	_____ Depression/ Anxiety	_____ Chemotherapy
_____ Head Injury	_____ Diabetes Type (I) ____or (II)____	_____ Radiation
_____ Epilepsy / Seizures	_____ Migraine	_____ Shingles

Please list any other medical conditions or history I should be aware of :_____