PATIENT INFORMATION

Last Name_____ First Name_____ M.I._____

Sex: M F Marital Status: S M D W DOB_____ Age____

Home Address_____

_____
city State zip code

Home # _____ Work/Cell # _____
Occupation_____ Primary Care Physician_____
E-mail address_____
Referral Source: Letter Newspaper Kaiser Internet
Doctor_____ Friend _____ Other _____

What brought you in today?_____
Have you ever been to this office before? Yes No

Health History

How is your general health?_____
History of diabetes?_____Allergies?_____
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 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
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?_____