First Name: **Last Name:** **Age:** **Date of Birth:**

Address

Address* **City*** **State*** **Zip***

Home Phone **Work Phone** **Cell Phone** **Email***

Gender*
○ **Male** ○ **Female** ○ **Other**

Social Security number **Driver's License**

Emergency Contact Information

Emergency contact name* **Relationship to patient*** **Phone***

Address* **City*** **State*** **Zip***

Referral Source

- ☐ Physician
- ☐ Yellow Pages
- ☐ Audiologist
- ☐ YellowPages.com
- ☐ Friend or Family Member
- ☐ Internet/Website
- ☐ Insurance Company or Hospital
- ☐ Marketing
- ☐ Other

Insurance Information

Insurance Name **Subscriber's Name** **Subscriber's Date of Birth** **Subscriber's SSN**

Subscriber's Relationship to Patient

Employer Name **Employer Phone** **Subscriber's policy number** **Group number**

Insurance claim mailing address

Do you have secondary insurance?
○ **Yes** ○ **No**

Secondary Insurance

Insurance Name	Subscriber's Name	Subscriber's Date of Birth	Subscriber's SSN
Subscriber's Relationship to Patient			
Employer Name	Employer Phone	Subscriber's policy number	Group number
Insurance claim mailing address			

Occupation:

Reason for visit:

Referring Doctor: **Referring Doctor Phone #:**

Family Doctor/Internist: **Family Doctor/Internist Phone #:**

Other Doctor Involved in Your Care: **Other Doctor Involved in Your Care Phone #:**

Drug allergies:

Ears:

Hearing loss	○ Right	○ Left	○ Both
Ear pain	○ Right	○ Left	○ Both
Ear drainage	○ Right	○ Left	○ Both
Ringing/noise	○ Right	○ Left	○ Both
Hearing aid	○ Right	○ Left	○ Both

Who is your hearing aid dispenser?

Noise Exposure:

Military	○ Yes	○ No	**Hunting**	○ Yes	○ No	**Firing range**	○ Yes	○ No
Trap shooting	○ Yes	○ No	**Small engines**	○ Yes	○ No	**Power tools**	○ Yes	○ No
Chain saws	○ Yes	○ No	**Snowmobiles**	○ Yes	○ No	**Motorcycles**	○ Yes	○ No

Occupational

Neurological

Spinning ○ Yes ○ No

Swimming sensation ○ Yes ○ No

Loss of balance ○ Yes ○ No

Veering to side ○ Yes ○ No

Falls ○ Yes ○ No

Lightheaded/giddy ○ Yes ○ No

Fainting/blackouts ○ Yes ○ No

Headaches ○ Yes ○ No

Migraine history ○ Yes ○ No

Previous head injury ○ Yes ○ No

Difficulty with speech/swallowing ○ Yes ○ No

Numbness/weakness of arms/legs ○ Yes ○ No

Facial weakness ○ Yes ○ No

Neck problems ○ Yes ○ No

Jaw problems ○ Yes ○ No

Previous Ear Surgeries:

Family History of Hearing Loss:

Past Medical History:

Current Medications:

Other Surgeries:

Family Medical History:

Father	○ **Alive** ○ **Deceased**	Age	Health status or cause of death
Mother	○ **Alive** ○ **Deceased**	Age	Health status or cause of death
Brother/Sister	○ **Alive** ○ **Deceased**	Age	Health status or cause of death
Brother/Sister	○ **Alive** ○ **Deceased**	Age	Health status or cause of death
Brother/Sister	○ **Alive** ○ **Deceased**	Age	Health status or cause of death

Social History

Marital Status

○ Married ○ Single ○ Divorced ○ Widowed

○ **Yes** ○ **No** How many?

Do you live alone? ○ **Yes** ○ **No** Who lives with you?

How much caffeine do you drink per day?

Coffee

Tea

Soda pop

Chocolate

How much salt do you eat?

○ **Low salt diet**

○ **No added salt**

○ **Regular intake**

Do you smoke?

○ **Yes**

○ **No**

Packs/day

E-cigarettes/day

Cigars/day

Do you smoke marijuana?

○ **Yes**

○ **No**

How much?

Do you drink alcohol?

○ **Yes**

○ **No**

Quantity?

Do you take any street drugs?

○ **Yes**

○ **No**

Please explain:

Are you at risk for AIDS (e.g. sexual orientation, drug abuse, previous blood transfusion)?

○ **Yes**

○ **No**

Please explain:

Eyes

Wear glasses	○ Yes ○ No	**Visual changes**	○ Yes ○ No
Glaucoma	○ Yes ○ No	**Cataracts**	○ Yes ○ No

Endocrine

Diabetes	○ Yes ○ No	**Thyroid Disease**	○ Yes ○ No
Hormone Problems	○ Yes ○ No	**Fever**	○ Yes ○ No
Weight Loss/Gain	○ Yes ○ No	**Excessive Fatigue**	○ Yes ○ No

Cardiovascular

Chest Pain or Angina	○ Yes ○ No	**High Blood Pressure**	○ Yes ○ No
Irregular Pulse	○ Yes ○ No	**Heart Murmur**	○ Yes ○ No
High Cholesterol	○ Yes ○ No	**Swelling in Feet or Hands**	○ Yes ○ No
Leg Pain while Walking	○ Yes ○ No		

Gastrointestinal

Indigestion	○ Yes ○ No	**Nausea**	○ Yes ○ No
Vomiting	○ Yes ○ No	**Liver Disease/Hepatitis**	○ Yes ○ No
Abdominal Pain	○ Yes ○ No	**Change in Bowel Habits**	○ Yes ○ No
Ulcers or Gastritis	○ Yes ○ No		

Nose

Nasal Congestion	○ Yes ○ No	**Nasal Drainage**	○ Yes ○ No
Sinus Problems	○ Yes ○ No	**Environmental Allergies**	○ Yes ○ No

Psychiatric

Anxiety	○ Yes ○ No	**Depression**	○ Yes ○ No
Insomnia	○ Yes ○ No	**Suicidal Thoughts**	○ Yes ○ No

Respiratory

Asthma	○ Yes ○ No	**Bronchitis**	○ Yes ○ No
Chronic Cough	○ Yes ○ No	**Emphysema**	○ Yes ○ No
Shortness of Breath	○ Yes ○ No	**Pneumonia**	○ Yes ○ No
Tuberculosis	○ Yes ○ No		

Genitourinary

Urinary Tract Infections	○ Yes ○ No	**Painful Urination**	○ Yes ○ No
Blood in your Urine	○ Yes ○ No	**Incontinence**	○ Yes ○ No
Difficulty Voiding	○ Yes ○ No		

The above information is accurate to the best of my knowledge.

Patient's Signature:

Signature

Date