BETTER LIFE HEARING

Please Fill out the information below.

Patient Name: _____ Date: _____

Date of Birth: _____ Sex: _____ Home/Cell Phone: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

E-Mail Address: _____ Primary Care Physician: _____

1. Chief complaint: ☐ Hearing Loss (Right ear/ Left ear/ Both) ☐ Tinnitus/Ringing ☐ Dizziness

☐ Difficulty hearing (☐ in Quiet ☐ in Noise) ☐ Telephone ☐ TV

2. How long have you noticed this difficulty? _____

3. Do you think your hearing is changing? ☐ Yes ☐ No (☐ Gradual ☐ Sudden)

4. Have you ever had your hearing tested? ☐ Yes ☐ No If so, when was your last test? _____

5. Do you have any of the following symptoms? ☐ Deformity of the ear ☐ Drainage of the ear ☐ Sudden or rapid loss within the past 90 days ☐ Acute or chronic dizziness/Imbalance ☐ Tinnitus(ringing) ☐ Ear pain

6. How did you hear about our practice? ☐ Internet ☐ Newspaper ☐ Social Media

6. Have you seen an Ear, Nose and Throat Physician? ☐ Yes ☐ No

If so, who did you see? _____ When? _____

7. Have you ever had surgery that may have affected your hearing? ☐ Yes ☐ No Type? _____

8. Is there a history of hearing loss in your family? ☐ Yes ☐ No If so, who? _____

9. Please rank the following in order of importance (1-4), if a hearing aid is recommended for you:

____ Improved hearing in quiet ____ Improved hearing in noise

____ Cosmetic appearance ____ Expense

10. If you are currently using a hearing aid, or have in the past, please answer the following:

Which ear is/was aided? ☐ Right ☐ Left ☐ Both

How long have you used a hearing aid? _____

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(Signature of Adult, or Guardian of children under the age 18)