PERSONAL INFORMATION FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Gender: _____ Date of Birth: _____ Email: _____

Home Phone: _____ Mobil Phone:_____

Marital Status: _____ Name:_____

Emergency Contact Name: _____

Relation: _____ Emergency Contact Number: _____

Primary Physician Name: _____ Phone: _____

Referring Physician Name: _____ Phone: _____

Insurance Company: _____

Member ID: _____ Phone Number: _____

Policy Holder _____ Relationship _____ DOB: _____

How did you hear about us?

☐ Physician Referral ☐ Referred by a friend ☐ Saw Sign

☐ Direct Mail ☐ Newspaper ☐ Internet

☐ Other, please explain_____

What is the purpose of your visit? Please check all that apply.

☐ Hearing Difficulties ☐ Pain/Discharge from ears

☐ Ringing in the ear(s) ☐ Information about hearing aids

☐ Other, please explain: _____

Are you being treated for any of the following?

☐ High Blood Pressure ☐ High Cholesterol ☐ Diabetes

□ Other: _____

Please list current medications:

Hearing History

1. Have you had your hearing tested before? Yes □ No □

   If yes, when and where? _____

   What were the results? _____

2. Have you noticed any drainage from your ears within the past 90 days? Yes □ No □
3. Have you experienced any balance problems, dizziness, or falls? Yes □ No □
4. Have you had any pain or discomfort in your ears in the last 90 days? Yes □ No □
5. Have you ever lost hearing in one ear suddenly? Yes □ No □ If yes, when? _____
6. Do you have any noises or ringing in your ears? Yes □ No □

   If yes, what Ear? Left □ Right □ Both □ Is it: Constant □ Intermittent □

   When did you first notice it? _____
7. Have you received any medical or surgical treatment for hearing loss? Yes □ No □
8. Have you ever been exposed to loud noise? Yes □ No □

   If yes, where did it occur: Military □ Occupation/Job □ Recreational □

   Do you use hearing protection? Yes □ No □
9. Is there a history of hearing loss in your immediate family? Yes □ No □

To help us better understand you and your hearing ability, please take a minute to complete the information below. Our hearing professional will discuss this with you during your appointment.

How important is it for you to improve how you're hearing today?

Place an **X** on the line.

Not at all important Extremely Important