hear for you
HEARING AID CENTER

Enjoy the sounds of life!

ADULT HEARING CASE HISTORY – CONFIDENTIAL PATIENT INFORMATION

Patient Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Email _____ @ _____

Primary Care Physician _____ Phone _____

Reason for today's visit _____

How did you hear about our practice? _____

Emergency Contact _____ Phone _____

Address _____ Relationship to Patient _____

Allergies _____

Please check any of the following that you currently have or have had in the past:

☐Arthritis ☐Asthma ☐Bell's Palsy ☐Diabetes ☐Head Injury ☐Heart Trouble ☐Hepatitis ☐High Blood Pressure ☐HIV
☐Malaria ☐Measles ☐Meningitis ☐Mumps ☐Neurological ☐Parkinson's ☐Scarlet Fever ☐Stroke/TIA ☐Visual Trouble

Please provide a complete list of the medications you are taking including reason you are taking it and dosing information

_____

_____

Have you been seen by a physician within the past 6 months? ☐Yes ☐No

Do you have any of the following symptoms? ☐Pain or discomfort in either ear ☐Acute or chronic drainage in either ear
☐Deformity of the ear ☐Rapid or sudden loss of hearing in the past 90 days ☐Feeling of fullness or pressure in either ear
☐Acute or chronic dizziness/Imbalance

Have you ever had surgery on either or both of your ears? ☐Yes ☐No

Have you ever had an ear infection? ☐Yes ☐No If yes, please indicate: ☐As a child ☐As an adult

Have you even been exposed to loud noise, either recently or in the past? ☐Yes ☐No

If yes, please mark all that apply: ☐Farm Machinery ☐Power Tools ☐Music ☐Military ☐Hunting/Shooting
☐Jet Engines ☐Factory Noise ☐Other