FAMILY HEARING CENTER FOLLOW-UP QUESTIONNAIRE

NAME _____ **DATE OF BIRTH**_____

ADDRESS _____ **CITY/STATE** _____

PHONE_____ **OCCUPATION** _____

MARITAL STATUS **M S D W** **WORK STATUS** **WORKING RETIRED**

Which ear is best? **Right Left** Do you hear noises/ringing in the ear(s)? **Right Left**

Do you have any dizziness, vertigo, nausea? _____

_____

Have you had recent earaches? **Y N** Ear infections? **Y N** Ear discharge? **Y N**

Have you had ear surgery since your last visit? **Y N** When? _____ What? _____

Name of ENT_____ Address _____

Name of Family Physician _____ Address _____

Which of these doctors would you like to receive the audiological report? _____

Amplification History

Do you wear your hearing aid? _____ If yes, how many hours a day? _____

Performance quality of present/past instrument(s) _____

Do you have any physical disabilities that may make it difficult to manipulate small controls? **Y N**

Insurance Information

Insurance _____ ID# _____

Name of Insured _____ Insured's Date of Birth _____

Insured's Address _____

Insured's Relationship to Patient _____ Insured's Employer _____

Please list all medications

(frequency & doseage:_____

_____

Administered Orally? **Y N** **OR** Other:_____