FAMILY HEARING CENTER NEW PATIENT QUESTIONNAIRE

NAME _____ **DATE OF BIRTH**_____

ADDRESS _____ **CITY/STATE** _____

PHONE_____ **OCCUPATION** _____

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

Who recommended that you come to our office? _____

Has your hearing been tested? **Y N** When? _____

Where? _____ By whom? _____

Recommendations: _____

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

Do you have any dizziness, vertigo, nausea? _____

_____

Do other members of your family have hearing problems? **Y N** Who? _____

Do you or have you ever worked in a noisy place? **Y N**

Are you exposed to noise in your pastimes or hobbies? **Y N**

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

Have you had ear surgery? **Y N** When? _____ What? _____

Treatment (Physician/Surgeon): _____

Communication Problems

Where do you have trouble hearing? ☐Radio/TV ☐Groups ☐Job ☐Noise ☐Large Rooms

Do you hear but have difficulty in understanding? **Y N**

Do you hear some people better than others? **Y N** Describe: _____

Do you use the telephone? **Y N** Can you hear it ringing? **Y N** Which ear do you use? **R L**

Do you avoid social situations you enjoy because of your hearing problem? **Y N**

If we find by our testing that you can be helped, are you ready for that help? **Y N**

Amplification History

Have you ever used a hearing aid? **Y N** If yes, please complete the following:

Type(s) _____ Ear(s) fitted **R L**

Brand(s) _____ When purchased _____

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**:**_____