PROFESSIONAL HEARING SOLUTIONS by Dr. Jill

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Patient Name: _____ Date: _____

Date of Birth: _____/_____/_____ Sex : M / F Circle one: Married / Single / Widow

Address: _____
(Street) (City/State/Zip Code)

Contact Phone No. (____) _____-_____ Text messages, ok? ____Yes ____NO

Alternate Phone No. (____) _____-_____ Email: _____

Spouse/Relative Name: _____ Relationship: _____

Primary Care Physician: _____ Office location: _____

Would you like a copy of your hearing test sent to your PCP? Circle one: Yes / No

Insurance Co: _____ Policy No. _____

How did you hear about us? _____

Medical History

Please provide a list of medications for us to copy for your chart, or list current medications, dosages and frequency, along with over-the-counter medications and vitamin supplements:

_____

_____

Have you been diagnosed with any of the following conditions?

____ Cardiovascular Disease ____ Parkinson's Disease

____ Dementia ____ Autoimmune Disorder

____ Diabetes ____ Sleep Apnea

____ Other chronic health conditions : _____

About your Ears

Deformity of the ear ? ____ Yes ____ No

Do you have sudden pain in your ears? ____ Yes ____ No

Sudden or long-term dizziness? ____ Yes ____ No

Sudden/rapid hearing loss in the past 90 days? _____ Yes _____ No

Hearing loss in one ear in the past 90 days? _____ Yes _____ No

Have you ever had wax removed from your ears? _____ Yes _____ No

Drainage from either ear in the past 90 days? _____ Yes _____ No

Have you ever had ear surgery? _____ Yes _____ No Date: _____

Which do you believe is your poorer ear? _____ Left _____ Right _____ Not sure/same

Have you ever seen an ENT (Ear, Nose & Throat) doctor regarding your ears, hearing, balance or tinnitus? _____ Yes _____ No

If you answered YES, please list the name of the ENT, the year and summary of the outcome:

_____

_____

About Your Hearing

When and where was your last hearing test? _____

Do you have ringing in your ears? _____ Yes _____ No

If YES, which ear? _____ Right _____ Left _____ Both

Please describe the sound: _____

Have you been exposed to excessive noise? _____ Yes _____ No

Veteran / Military? _____ Yes _____ No **If YES,** please describe your exposure to loud noise:

_____

Have you ever worn a hearing instrument? _____ Yes _____ No **If YES,** please list:

Date fitted: _____

What Brand: _____

What Type: _____

Results: _____

If you DO have difficulty hearing, please list 3 situations you would most like to improve (For example, understanding voices on TV, understanding my family, hearing better in groups, etc.)

1. _____

2. _____

3. _____

Signing below, you allow us to release all medical information to your insurance carrier(s) as needed. **You agree to accept financial responsibility for all charges which are non-covered and thus not paid to us by your insurance carrier(s) for services rendered by our office.** This release is valid for life but may be revoked, in writing, at any time. Refusal to sign or revocation of this release will result in you being financially responsible for payment in full at the time of the visit. **Please Note:** Ear wax removal is covered by insurance in an audiologist's office. Separate fees will apply if you require this prior to testing.

Signature of Patient: _____

Printed Name: _____ Date signed: _____