Hearing Professionals of Alabama, LLC

PATIENT INTAKE FORM

Patient History

Today's Date _____

Last Name_____**First Name**_____**MI** ____

Address_____**City**_____**State** _____
Zip Code _____

Phone_____**Alternate Phone**_____**Email address** _____

Date of Birth _____ ☐ **Male** ☐ **Female** ☐ **Married** ☐ **Single** ☐**Widow(er)**

Past/Present Occupation _____

Accompanying Party _____ **Relationship to Patient** _____

Referring Physician Name _____

How did you hear about us? _____

Medical and Hearing Health History

Do you have any of the following:

Deformity of the ear?	☐ **YES** ☐ **NO**
Sudden or rapid hearing loss in the past 90 days?	☐ **YES** ☐ **NO**
Pain of discomfort in the ear?	☐ **YES** ☐ **NO**
Acute or recurring dizziness?	☐ **YES** ☐ **NO**
Previous ear infections?	☐ **YES** ☐ **NO**
Active drainage from the ear?	☐ **YES** ☐ **NO**

Have you ever found it necessary to have a doctor remove wax from your ear? ☐ **YES** ☐ **NO**

In which ear do you feel you are hearing the worst? ☐ **BOTH** ☐ **LEFT** ☐ **RIGHT**

Hearing Professionals of Alabama, LLC

Medical and Hearing Health History (continued)

Do you have any sinus or allergy problems? ☐ YES ☐ NO
If YES, please list: _____

Are you a diabetic? ☐ YES ☐ NO
If YES, are you insulin-dependent? ☐ YES ☐ NO

Have you ever been exposed to excessive loud noise? ☐ YES ☐ NO

Do you have a history of firearm use? ☐ YES ☐ NO

Do you have ringing or other noises in your ears? ☐ YES ☐ NO
If YES, which ear? _____

Have you ever had your hearing tested? ☐ YES ☐ NO
If YES, by whom and when? _____

Have you ever received any medical or surgical treatment for your ears or hearing loss? ☐ YES ☐ NO
If YES, explain and include dates if possible _____

_____

Please list any medications you are currently taking here or provide a copy of a list _____

_____

_____

Amplification History

Do you currently wear any amplification device? ☐ YES ☐ NO

If YES, what type? _____ **Which ear?:** ☐ BOTH ☐ LEFT ☐ RIGHT
Age of Device(s)? _____

If YES, and you could improve something about your current device, what would that be?

_____

_____

Do you know anyone who wears hearings aids? ☐ YES ☐ NO

If YES, who? _____

Is there anything else you would like us to know about yourself or medical history that was not included on this form? _____

_____