

## New Patient Confidential Information

### General Information:

Full Name: \_\_\_\_\_ Preferred Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  Male  Female

Marital Status:  Single  Widowed  Married Name of Spouse: \_\_\_\_\_

Employment Status:  Retired  Full Time  Part Time Occupation: \_\_\_\_\_

Snowbird Address (if applicable):

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

### Emergency Contact Information:

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

### Medical History:

Primary Physician: \_\_\_\_\_ City: \_\_\_\_\_

Have you ever seen an ear doctor? Name: \_\_\_\_\_ Date: \_\_\_\_\_

Have you ever had ear surgery? Type: \_\_\_\_\_ Where/When: \_\_\_\_\_

Have you ever had your hearing tested?  Yes  No Date of Test: \_\_\_\_\_

Tested by: \_\_\_\_\_ Results of test: \_\_\_\_\_

Does anyone in your family have a hearing problem?  Yes  No Relationship: \_\_\_\_\_

Do you now or have you ever worn a hearing instrument?  Yes  No Date Fit: \_\_\_\_\_

What brand/type? \_\_\_\_\_ Results? \_\_\_\_\_

Is there a history of diabetes in your family?  Yes  No Relationship: \_\_\_\_\_

Please list all the conditions for which you currently take medications \_\_\_\_\_

Are you taking any blood thinning medication?  Yes  No

How did you hear about us? \_\_\_\_\_

### Insurance Information:

\*\*\*Please allow us to copy your insurance card(s)\*\*\*

**If you are not the primary insured Please complete:**

Name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

By signing this document you are affirming that all the information you have provided is accurate to the best of your knowledge.

Name: \_\_\_\_\_ Date: \_\_\_\_\_

**About Your Ears:**

*Do you currently have any of these symptoms?*

- 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 that occurred 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
- ringing in the ears?  Yes  No

If yes, please describe the sound \_\_\_\_\_

Which do you believe is your poorer ear?  Left  Right  Not Sure/Same

**About Your Hearing:**

Have you been exposed to excessive noise? Yes / No What? \_\_\_\_\_

Do your friends and/or family complain that you do not hear well? Yes / No

If yes, What do they notice about your hearing or how would they describe your hearing problems:

\_\_\_\_\_

How long have you had a hearing problem? \_\_\_\_\_

**Do you experience difficulty with:**

Understanding all the words in a conversation clearly Yes / No

Hearing in a crowd or other noisy situations where background noise is present? Yes / No

Hearing on the telephone? Yes / No

**Perception of Hearing Questionnaire:**

*Listed below are several statements that describe hearing difficulties you may encounter. Please indicate how often you think each situation is true.*

	<b>Seldom</b>				<b>Always</b>
Problems hearing over the phone	1	2	3	4	5
Trouble following conversation in a small group of people	1	2	3	4	5
Trouble understanding TV	1	2	3	4	5
Trouble understanding in large rooms like lecture halls	1	2	3	4	5
Trouble understanding in restaurants and parties	1	2	3	4	5
Confusion about where sounds are coming from	1	2	3	4	5
Often have to ask people to repeat themselves	1	2	3	4	5
Misunderstanding instructions given by doctors and pharmacists	1	2	3	4	5
Find that people sound like they are mumbling or not speaking clearly	1	2	3	4	5
Trouble conversing in the car	1	2	3	4	5