Hear-Again Hearing Center
Patient Summary

Identity (PLEASE PRINT)

Patient's Name ____ Date of Birth ________________
FIRST MIDDLE INTIAL LAST

Address ________________________________ City: ____________________ State ____ Zip ________

Home Phone ___________________ Cell __________________ Email _______________________

Snowbird Address ____

Employment Status (Please circle one)

Full Time Part Time Not Employed Self Employed Retired Active Military Student

Marital Status (Please circle one)

Single Married Divorced Widowed Spouse Name _______________________________________

Emergency Contact

Name ___________________________ Phone_________________ Relationship to Patient _____________

Insurance

Primary _____________________________ ID/Policy No. _______________ Group No. ________________

Secondary ________________ ______________ ID/Policy No. _______________ Group No. ________________

Primary Insured ____________________________________ Insured Date of Birth ________________

Insured Employer ___________________________________ Relationship to Patient ________________

Primary Care

Physician ________________________ Practice Name ______________________ Phone ______________

Address ___________________________________ City: ________________ State ____ Zip ________

Permission to release test results to physician ___ YES ___ NO

How did you hear about us? (Please circle one)

Radio Mail Yellow Pages Newspaper/Coffee News Internet/Social Media Physician Insurance Referral__________________

Updated 4/2017

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Medical History (Please check all that apply)

Do you have pain/discomfort in your ear? Right _____Left _____ ____________________

Do you have you any drainage in your ear? Right _____Left _____ ____________________

Do you have a history of ear infections? Right _____Left _____ ____________________

Do have ringing or other noises in your ear? Right _____Left _____ ____________________

Do you have dizziness or vertigo? Yes _____ No _____ ____________________

Have you ever had ear surgery? Right _____Left _____ ____________________

Have you seen your physician regarding any of the above? ____________________

Please describe other medical conditions we should be aware of: ____________________

Please list your medications (or provide a copy at your appointment): ____________________

____

Hearing History

Do you think you have a hearing loss? Yes ____ No ____ If yes, which ear? Right ____ Left ____

Is there a family history of hearing loss? Yes ____ No ____ If yes, who: ____________________

Have you ever been exposed to loud noise? Yes ____ No ____ If yes, please specify ____________________

Have you had your hearing tested before? Yes ____ No ____ When__________________ Results ____________________

Beside each statement, mark 1, 2 or 3 to describe your experience in each situation using the following scale:

Rarely ❶ Occasionally ❷ Frequently ❸

I have to ask people to repeat themselves even when I am in a quiet conversation with 1-2 other people. _____

My family members complain that I need to turn the television volume louder than they do. _____

When I talk on the phone or cell phone, I miss some of what is being said. _____

I have difficulty hearing conversation when talking with a small group of 3-4 other people. _____

When I am in a busy public place, such as a shopping center, I have difficulty communicating with others. _____

In meetings, I have to strain to make sure I hear everything. _____

When I am eating in a restaurant, I have to ask my dining companion(s) to repeat things. _____

I miss a lot of information during church, theatrical performances and/or classroom lectures. _____

When I am listening to music/concerts, I miss part of the performance. _____

If I am in the car with others who are talking, I can't hear what they are saying. _____

Hearing Aid History

Do you currently use a hearing aid? Yes ____ No ____ If yes: Right ____ Left ____ How long? ______

How satisfied are you with your current hearing aids? Highly ____ Somewhat ____ Not at all ____

Describe what you like about your current hearing aids? ____________________

If there is one thing you could change about your current hearing aids, it would be? ____________________