

Hear-Again Hearing Center Patient Summary

Identity (PLEASE PRINT)

Patient's Name _____ Date of Birth _____
FIRST MIDDLE INITIAL 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 _____

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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 **1** Occasionally **2** Frequently **3**

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? _____