Patient Information

Patient Name _____ Email: _____

Age _____ Date of Birth _____ Sex: M F Marital Status: M S W D SEP.

Home Telephone #: _____ Work Telephone #: _____Cell Phone#: _____

Street Address _____Town_____State_____Zipcode_____

2nd Home Address _____

Occupation: _____ If retired, former occupation: _____

Please present insurance cards to receptionist for photocopy

Primary Insurance Co._____Secondary Ins. Co._____ _____

Who referred you to our practice? _____ Primary Care Physician:_____

I authorize payment of medical benefits to Cathleen A. Alex, Au.D., LLC for services rendered. I also authorize the release of any medical information to process this claim. I understand that I am responsible for any co-pays, deductibles, or uninsured expenses.

Signed _____ Date_____

1. What is your primary concern for today's visit? _____
2. How long have you noticed this problem? _____
3. Was the onset sudden or gradual? _____
4. Have you previously consulted another professional regarding this problem? If so, whom and when?

   _____
5. Have you ever had a hearing test before? ☐ Yes ☐ No
   If so, please explain: _____
6. Is the hearing better in one ear? ☐ Yes ☐ No
   If so, which ear? ☐ Right ☐ Left
7. Does your hearing ever change or fluctuate? ☐ Yes ☐ No
   If so, please explain: _____
8. Have you ever been exposed to loud sounds? ☐ Yes ☐ No
   If so, please mark all that apply:
   ☐ Machinery ☐ Music ☐ Firearms ☐ Factory ☐ Military ☐ Tools ☐ Other: _____
   If so, did you wear hearing protection? ☐ Yes ☐ No
9. Is there a family history of hearing loss or ear issues? ☐ Yes ☐ No
   If so, please explain: _____
10. Do you have ringing or noises in your ears? ☐ Yes ☐ No
    If so, which ear? ☐ Right ☐ Left ☐ Both

    ☐ Ringing ☐ Static ☐ Hissing ☐ Chirping ☐ Pulsing ☐ Buzzing ☐ Other: _____

    Is the sound constant or periodic? ☐ Constant ☐ Periodic, how often? _____
11. Do you have a history of ear infections or surgeries? ☐ Yes ☐ No
    If so, please explain: _____

12. In the past 90 days have you experienced any of the following?
Please mark all that apply:

☐ Ear Pain/Discomfort	☐ Right	☐ Left	☐ Both
☐ Ear Drainage	☐ Right	☐ Left	☐ Both
☐ Fullness/Pressure	☐ Right	☐ Left	☐ Both

13. Do you have a history of head, neck, or ear injuries? ☐ Yes ☐ No
If so, please explain: _____

14. Do you have dizziness or vertigo? ☐ Yes ☐ No
If so, please explain: _____

15. Do you use any form of tobacco? ☐ Yes ☐ No
If so, please explain: _____

16. Which of these listening situations are problematic for you?
Please mark all that apply:

☐ Spouse/Family	☐ Restaurants	☐ Social Settings	☐ Television
☐ Hobbies (_____)	☐ Telephone	☐ Place of Worship	☐ Radio
☐ Work	☐ Meetings	☐ Group Gatherings	☐ Other: _____

17. Do you currently have hearing aids? ☐ Yes ☐ No
If so, where and when did you get them: _____

18. Do you believe you need hearing aids? ☐ Yes ☐ No
If so, please rank the following by importance:
☐ Improvement in Quiet ☐ Improvement in Noise ☐ Cosmetics ☐ Cost

19. Please check any of the following that you currently have or have had in the past?

☐ Arthritis	☐ HIV	☐ Malaria	☐ Pacemaker
☐ Asthma	☐ Head Injury	☐ Measles	☐ Parkinson's
☐ Bell's Palsy	☐ Heart Issue	☐ Meningitis	☐ Sinusitis
☐ Cancer	☐ Hepatitis	☐ Mumps	☐ Stroke/TIA
☐ Diabetes	☐ High Blood Pressure	☐ Neurological Issue	☐ Visual Trouble-Loss/Sight

20. Are you currently taking any medications? (include over the counter) ☐ Yes ☐ No

Medication	Condition	Dosage	Frequency