

**Identifying and Family Information**

Patient Information:			
Patient Name:	Date of Birth:	Age:	Gender: <input type="checkbox"/> M <input type="checkbox"/> F
Street Address:	Town:	State:	Zipcode:
Secondary Address:	Town:	State:	Zipcode:
Primary Phone:	Cell:	Preferred Phone: <input type="checkbox"/> Home <input type="checkbox"/> Cell	
Email:	Marital Status: <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> SEP		
Occupation:	If retired, former occupation:		
Who referred you to our practice?		Primary Care Physician:	
<b>What is your main concern for today's visit?</b>			

Insurance Information:	
Primary Insurance Company:	Policy Holder's Name:
Policy Holder's Relationship to Patient:	Policy Holder's Date of Birth:
Secondary Insurance Company:	Policy Holder's Name:
Policy Holder's Relationship to Patient:	Policy Holder's Date of Birth:
<b><i>I authorize payment of medical benefits to Southbury Audiology, 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.</i></b>	
<b>Signed:</b>	<b>Date:</b>

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How long have you noticed this problem?

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Was the onset sudden or gradual?

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Have you previously consulted another professional regarding this problem? ☐ Yes ☐ No  
 If so, whom and when?

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Have you ever a hearing test before? ☐ Yes ☐ No  
 Please Explain:

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Is the hearing better in one ear? ☐ Yes ☐ No  
 If so, which ear? ☐ Right ☐ Left

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Does your hearing ever change or fluctuate? ☐ Yes ☐ No  
 Please Explain:

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Have you ever been exposed to loud sounds? ☐ Yes ☐ No

☐ Machinery ☐ Music ☐ Firearms ☐ Factory ☐ Military ☐ Tools ☐ Other:

Did you wear hearing protection? ☐ Yes ☐ No

Is there a family history of hearing loss or ear issues? ☐ Yes ☐ No

Please Explain:

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Do you have ringing or noises in your ears? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<input type="checkbox"/> Right Ear <input type="checkbox"/> Left Ear <input type="checkbox"/> Both Ears <input type="checkbox"/> Constant <input type="checkbox"/> Periodic, how often: _____ Please describe: <input type="checkbox"/> Ringing <input type="checkbox"/> Static <input type="checkbox"/> Hissing <input type="checkbox"/> Chirping <input type="checkbox"/> Pulsing <input type="checkbox"/> Buzzing <input type="checkbox"/> Other: _____			
Do you have a history of ear infections or surgeries? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Please explain: _____			
In the past 90 days have you experienced any of the following:			
<input type="checkbox"/> Ear Pain or Discomfort <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Ear Drainage <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/> Ear Fullness or Pressure <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both			
Do you have a history of, or currently have dizziness or vertigo? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Please Explain: _____			
Do you have a history of head, neck, or ear injuries? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Please Explain: _____			
Do you use any form of tobacco? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Please Explain: _____			
Which of these listening situations are problematic for you?			
<div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> Spouse/Family  <input type="checkbox"/> Television  <input type="checkbox"/> Radio  <input type="checkbox"/> Group Gatherings           </div> <div> <input type="checkbox"/> Restaurants  <input type="checkbox"/> Telephone  <input type="checkbox"/> Work  <input type="checkbox"/> Hobbies: _____           </div> <div> <input type="checkbox"/> Social Settings  <input type="checkbox"/> Place of Worship  <input type="checkbox"/> Meetings  <input type="checkbox"/> Other: _____           </div> </div>			
Do you currently have hearing aids? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Where and when did you get them? _____			
Do you believe you need hearing aids? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
<i>Please rank by order of importance:</i>			
<input type="checkbox"/> Improvement in Quiet <input type="checkbox"/> Improvement in Noise <input type="checkbox"/> Cost <input type="checkbox"/> Cosmetics			
Do you believe you have insurance coverage for hearing aids? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
If yes, do you know the coverage? _____			
Have you ever been treated for cancer? <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Type/Treatment? _____			
Have you ever had, or do you currently have any of the following?			
<div style="display: flex; flex-wrap: wrap;"> <div style="width: 25%;"> <input type="checkbox"/> Alzheimer's Disease  <input type="checkbox"/> Anxiety and/or Depression  <input type="checkbox"/> Arthritis  <input type="checkbox"/> Asthma  <input type="checkbox"/> Bell's Palsy  <input type="checkbox"/> Chronic Congestion           </div> <div style="width: 25%;"> <input type="checkbox"/> Diabetes  <div style="margin-left: 20px;"><input type="checkbox"/> Type I   <input type="checkbox"/> Type II</div> <input type="checkbox"/> Heart Issue  <input type="checkbox"/> Headache/Migraine  <input type="checkbox"/> Hepatitis  <input type="checkbox"/> High Blood Pressure           </div> <div style="width: 25%;"> <input type="checkbox"/> HIV  <input type="checkbox"/> Malaria  <input type="checkbox"/> Measles/Rubella  <input type="checkbox"/> Meningitis  <input type="checkbox"/> Mumps  <input type="checkbox"/> Neurological Issue           </div> <div style="width: 25%;"> <input type="checkbox"/> Pacemaker  <input type="checkbox"/> Parkinson's  <input type="checkbox"/> Sinusitis/Allergies  <input type="checkbox"/> Stroke/TIA  <input type="checkbox"/> Tremors  <input type="checkbox"/> Visual Trouble           </div> </div>			
Are you currently taking any medications? (include over the counter) <span style="float: right;"><input type="checkbox"/> Yes <input type="checkbox"/> No</span>			
Medication	Condition	Dosage	Frequency

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