Hearing Dynamics LLC

Today's Date: _____

CONFIDENTIAL PATIENT INFORMATION

Name: _____
Title (Mr./Mrs. Ms.) First Last Suffix (I, II, Jr. Sr.)

Preferred Name: _____

Date of Birth: _____ **Sex:** ☐ Male ☐ Female ☐ Not specified

Family/Spouse/Guardian: _____

Marital Status:
☐ Single ☐ Married ☐ Divorced ☐ Partner ☐ Widowed ☐ Legally Separated ☐ Other

Employment Status:
☐ Full-time ☐ Part-time ☐ Self Employed ☐ Not Employed ☐ Retired ☐ Active Military
☐ Full-time student ☐ Part-time student ☐ Disabled

Email Address: _____

Home Address: _____
Street City State Zip

Mailing Address: (PO BOX) _____
Street City State Zip

Home Phone: _____ **Cell Phone:** _____

Emergency Contact: _____
Name Phone Number Relationship

Race:
☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐ White

Ethnicity:
☐ Not Specified ☐ No, not Hispanic/Latino ☐ Yes, Hispanic/Latino

Primary Language: _____

Referral Source: ☐ Doctor Referral ☐ Newspaper ☐ Walk In ☐ Online
☐ Friend/Family ☐ Senior Center ☐ Phone Book ☐ TV
☐ Customer Referral Other: _____

Please List Your Hobbies: _____

_____

Have you ever had a hearing test? ☐ Yes ☐ No If yes, when? _____
Additional comments: _____

Do you experience hearing loss? ☐ Yes ☐ No If yes, which ear? ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it? ☐ Gradual ☐ Sudden ☐ Fluctuating

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Which ear do you use to talk on the phone? ☐ Right ☐ Left ☐ Both

Have you ever worn or tried a hearing aid? ☐ Yes ☐ No
If yes, describe your experience: _____

Does a hearing loss make you feel embarrassed when you meet new people?
☐ Yes ☐ No ☐ Sometimes Additional comments: _____

Does a hearing problem cause you to feel frustrated when talking to members of your family?
☐ Yes ☐ Sometimes ☐ No

Do you have difficulty when someone speaks in a whisper? ☐ Yes ☐ Sometimes ☐ No

Do you feel handicapped by a hearing problem? ☐ Yes ☐ Sometimes ☐ No

Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?
☐ Yes ☐ Sometimes ☐ No

Does a hearing problem cause you to attend religious services less often than you would like?
☐ Yes ☐ Sometimes ☐ No

Does a hearing problem cause you to have arguments with family members?
☐ Yes ☐ Sometimes ☐ No

Does a hearing problem cause you difficulty when listening to TV or radio?
☐ Yes ☐ Sometimes ☐ No

Do you feel that any difficulty with your hearing limits or hampers your personal or social life?
☐ Yes ☐ Sometimes ☐ No

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?
☐ Yes ☐ Sometimes ☐ No

If a hearing loss is discovered are you ready for help today? ☐ Yes ☐ No

Are you aware of the significant medical and communicative consequences of untreated hearing loss?

☐ Yes ☐ No

Have you experienced any of the following major medical conditions (please check all that apply):

☐ AIDS/HIV
☐ Appetite Change
☐ Arthritis
☐ Blood Disorders
☐ Cancer
☐ Chicken Pox
☐ Diabetes
☐ Diphtheria
☐ Encephalitis
☐ Fatigue
☐ Genetic Disorders
☐ Headaches
☐ Head Injury
☐ Heart Problems
☐ High Blood Pressure
☐ High Fevers
☐ Influenza
☐ Malaise
☐ Malaria
☐ Measles
☐ Meningitis
☐ Mumps
☐ Scarlet Fever
☐ Stroke
☐ Tonsillitis
☐ Typhoid
☐ Vascular Problems
☐ Other _____

Please check all medial symptoms that apply:

☐ Eye problems (such as blurred vision, pain)
☐ Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain)
☐ Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations)
☐ Respiratory Symptoms (such as shortness of breath, cough, wheezing)
☐ Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea)
☐ Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma)
☐ Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness)
☐ Psychiatric Issues (such as depression, anxiety, compulsions)
☐ Endocrine Symptoms (such as frequent urination, hot flashes)
☐ Hematologic / Lymphatic Systems (such as bleeding gums, bruising, swollen glands)
☐ Allergic / Immunologic Systems (such as hives, asthma, Itching, immune deficiency)

Additional comments: _____

Any history of significant illnesses, surgeries, injuries or hospitalizations?

_____

Current Medications:

Drug Name	Dose	Frequency	Delivery Method
Drug Name	Dose	Frequency	Delivery Method

Current Medications Cont.:

Drug Name	Dose	Frequency	Delivery Method
Drug Name	Dose	Frequency	Delivery Method
Drug Name	Dose	Frequency	Delivery Method

Allergies (food, medications, plastics, etc.):

Do you currently use tobacco? ☐ Yes ☐ No

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely