HEARING SOLUTION CENTERS

PATIENT ASSESSMENT

Today's Date _____/_____/_____

Name _____

DOB _____/_____/_____ Age _____

Mailing Address _____

City _____ State _____ Zip_____

Cell Phone _____ Home Phone _____

Work Phone _____ Email _____

Occupation *(If retired, past occupation)* _____

Marital Status: Married ☐ Widowed ☐ Divorced ☐ Single ☐

Emergency Contact Name _____

Phone _____ Relationship _____

Primary Physician Name _____

City _____ Phone _____

Is it necessary for a family member to help you make a decision about wearing hearing devices? Yes ☐ No ☐

When was your last hearing test? _____

By whom? _____

Please select your answer to the following questions:

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

Have you ever had ear surgery? Yes ☐ No ☐

Do you have drainage from your ear(s)? Yes ☐ No ☐

Do you have acute or recurring dizziness? Yes ☐ No ☐

Has your hearing gotten worse in the past 3 months? Yes ☐ No ☐

Do you have ear pain? Yes ☐ No ☐

Have you ever had a doctor remove wax from your ear(s)? Yes ☐ No ☐

Do you have noises in your ears like buzzing, ringing, or clicking? Yes ☐ No ☐

Which ear do you hear BETTER from? Left ☐ Right ☐ Both ☐

How long have you had hearing trouble? Just recently ☐ 1-5 yrs ☐ 6-10 yrs ☐ 10+ yrs ☐

Do you currently wear a hearing device(s)? Yes ☐ No ☐

If so, which ear(s) do you wear them in? Left ☐ Right ☐ Both ☐

If a hearing aid would help you hear better, would you wear them? Yes ☐ No ☐

Have you ever had Chemotherapy? Yes ☐ No ☐

Do you have Diabetes? Yes ☐ No ☐

Do you have any heart issues? Yes ☐ No ☐

What?_____

Do you have High Blood Pressure? Yes ☐ No ☐

Medications may have side effects that can affect your hearing.

If you are not currently taking any medications, check **NONE**. ☐

Please list all your medications as best you can here OR give your list to our staff and we can simply scan it into our records.

Name of Medication	Dosage	How often is it taken?	What is it used for?
Example: Celebrex	*100mg*	*Twice a day? Four times a day?*	*Blood pressure? Cancer treatment?*

HIPAA and Privacy Policy

Please give your insurance information to our Staff so we can make a copy for our records.

I understand I am responsible for co-pays, deductibles, & coinsurance portions not paid by my insurance company and items not specifically covered by my insurance, according to my specific insurance plan.

I acknowledge that I have a right to receive a copy of the HIPAA Acknowledgement & Privacy Policy which describes how my protected health information is used.

_____ _____

Signature *Date*