History & Needs Assessment

Name________________________________Phone__________________Date_____________

Address________________________________Date of Birth________________Age________

City__________________________State____Zip__________E-mail______________________

Marital Status: ☐ Single ☐ Widowed ☐ Married Name of Spouse_______________

Employer_____________________Occupation________________Soc. Sec. #______________

Emergency Contact Name___________________Phone____________Relationship___________

Medical Insurance________________________Hearing Aid Ins. Benefit? ☐ Yes ☐ No

How Did You Hear About Us? ☐ Patient Referral ☐ Physician Referral ☐ Nursing Home

☐ Website / Online ☐ Direct Mail ☐ Sign / Drive By ☐ Newspaper

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Name of primary care physician or referring physician_________________________________

Have you ever seen an ear, nose, and throat specialist? ☐ Yes ☐ No When?____________

Have you ever had your hearing tested? ☐ Yes ☐ No If yes, hearing loss?___________

Have you ever had or currently have hearing aids? ☐ Yes ☐ No

If you currently wear hearing aids, how old are they?_______ Brand/Style _________________

Have you ever had or currently have any of the following: ☐ Ear Surgery ☐ Ear Infections

☐ Ringing in the Ears ☐ Chemotherapy / Radiation Therapy ☐ Dizziness/Vertigo

☐ Deformity of the Ears ☐ Ear Pain ☐ Ear Drainage ☐ Sudden Hearing Loss

☐ History of Falling ☐ History of Depression ☐ Diabetes ☐ Hepatitis ☐ Tobacco Use

☐ Hole in the eardrum ☐ PE Tubes in ears ☐ HIV/AIDS ☐ Hemophilia

☐ Noise Exposure ☐ Family members with hearing loss - Relation to you_______________

Ever seen a doctor for wax removal? ☐ Yes ☐ No Your better ear: ☐ Right ☐ Left

How many prescription drugs do you take daily?______List all meds:________________________

Do you take blood thinners? ☐ **Yes** ☐ **No** **If yes, what kind?**____________________________

Do you currently have a pacemaker? ☐ **Yes** ☐ **No** **If yes, which side?** ☐ **Right** ☐ **Left**

On a scale of 1-10, 1 being the best and 10 being the worse, how would you rate your overall hearing ability? (please circle one)

Best **1** **2** **3** **4** **5** **6** **7** **8** **9** **10** **Worst**

Describe which situations are the most difficult hearing for you?

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What is your primary reason for today's visit?

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