



**PATIENT INFORMATION FORM- ADULT**

Patient Name (First, Middle, Last) \_\_\_\_\_

Name Patient goes by (if different from given name): \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender: \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Primary Language: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Primary Phone Number: \_\_\_\_\_ Cell Home

Secondary Phone Number: \_\_\_\_\_ Cell Home

Email Address: \_\_\_\_\_

Current Employer: \_\_\_\_\_

Family Physician/Clinic Name: \_\_\_\_\_

Marital Status: Married Single Divorced Widowed

Spouse/Partner Name & Phone Number: \_\_\_\_\_

Emergency Contact & Phone Number: \_\_\_\_\_

We are a teaching clinic; are you comfortable being seen by an Audiology Student? \_\_\_\_\_

**Please provide Patient Care Coordinator's with your insurance card(s)  
Please provide Power of Attorney or guardian paperwork if applicable**

**Authorization for Treatment:** I consent to treatment from Professional Hearing Services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**We will send a copy of your test results and/or report to your referring or ordering physician. If you would like any additional physicians and/or other entities to receive a copy of your tests and/or report, please notify our receptionist and complete a records release.**



Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**HEARING HEALTH QUESTIONNAIRE:**

What is your chief complaint/reason for your visit? \_\_\_\_\_

Do you feel you may have hearing loss? \_\_\_\_\_ If so: Right ear Left ear Both ears

What do you feel is the cause of your hearing loss? \_\_\_\_\_

When did you first notice your hearing loss? \_\_\_\_\_

Date of your last hearing test? \_\_\_\_\_

**What listening environments do you currently struggle with to understand conversation, if any? Circle all that apply**

- |  |                          |
|--|--------------------------|
| a) Home/ quiet situations                | b) Watching television   |
| c) Cell phone/telephone use              | d) Work                  |
| e) Meetings                              | f) Church/lectures       |
| g) Social gatherings (i.e., restaurants) | i) Sporting/large events |

Please list any other situations where you have hearing difficulty:

\_\_\_\_\_

**If you find out you have hearing loss, are you ready for help? Yes No Maybe**

Do you currently wear hearing aids? Yes No Hearing Aid Brand: \_\_\_\_\_

Where did you get your hearing aids? \_\_\_\_\_

When did you get your hearing aids? \_\_\_\_\_

**What problems do you have with your hearing aids? Circle all that apply**

- |                                      |                                 |
|--------------------------------------|---------------------------------|
| a) I have them, but do not wear them | b) Some sounds are too loud     |
| c) Sounds are too soft               | d) Pain (Please explain) _____  |
| e) Sounds are tinny or metallic      | f) Trouble cleaning hearing aid |
| g) Naturalness of sound              | h) Concerns: _____              |

**Please check all medical conditions that apply:**

\_\_\_\_\_ History of Chemo/Radiation. If checked, please explain \_\_\_\_\_

\_\_\_\_\_ History of diabetes.

\_\_\_\_\_ Memory issues. If checked, have you told your doctor? \_\_\_\_\_

\_\_\_\_\_ Have had an MRI of your head. If checked, please explain \_\_\_\_\_

\_\_\_\_\_ History of loud noise exposure. If checked, please explain \_\_\_\_\_

\_\_\_\_\_ Dizziness or Unsteadiness. If checked, have you told your doctor? \_\_\_\_\_

\_\_\_\_\_ Ear Drainage. If checked:      Right Ear      Left Ear      Both Ears

\_\_\_\_\_ Ear Pain. If checked:              Right Ear      Left Ear      Both Ears

\_\_\_\_\_ History of Stroke/ Heart Issues. If checked, please explain \_\_\_\_\_

\_\_\_\_\_ On Blood Thinners. If checked, please explain \_\_\_\_\_

\_\_\_\_\_ Autoimmune Disorder. If checked, please explain \_\_\_\_\_

\_\_\_\_\_ Family history of hearing loss. If checked, who? \_\_\_\_\_

\_\_\_\_\_ History of ear infections. If checked:    Right Ear      Left Ear      Both Ears

\_\_\_\_\_ History of ear wax build-up:    Yes      No

\_\_\_\_\_ Previous ear surgery. If checked, please explain: \_\_\_\_\_

\_\_\_\_\_ Tinnitus/Ringing/Noises in Ears/Rushing Noise. If checked, please describe the sound(s) you hear in your ears: \_\_\_\_\_

Please list any other medical information if not listed here.

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