Confidential Patient Information

NAME _____ DATE _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE_____

TELEPHONE # _____ DATE OF BIRTH_____

PRIMARY PHYSICIAN'S NAME _____

Insurance Carrier_____ ID# _____

Would you like a copy of your hearing test sent to your physician? Yes No

Do you have any of these symptoms?

Drainage from either ear?	___	___
Sudden or long term dizziness?	___	___
Excessive wax in either ear?	___	___
Ringing or unusual noises in either ear?	___	___
Pain in either ear?	___	___
Dramatic change in hearing in the past 90 days?	___	___

Have you ever had ear surgery? Yes___ No___ If yes, when & for what?_____

_____

Have you ever been exposed to loud noise? Yes___ No___

If yes, to what and for how long? _____

_____

Do you hear better on one side? Yes___ No___ If yes, which side? Left___ Right___

Have you ever had a hearing test? Yes___ No___ If yes, when?_____

What were the results? _____

Under what circumstances is it hardest for you to hear?

TV___ Telephone___ Church___ Groups___ Conversation___

Is there a history of hearing loss in your family? Yes___ No___

Do you now or have you ever used a hearing instrument? Yes___ No___

If yes, please state brand name and approximate year of purchase: _____

How did you hear about us?

TV___ Newspaper___ Direct Mail___ Referral___ Phone Book___ Other___

If you were referred, from whom? _____

What are your chief concerns? _____

_____

APEX AUDIOLOGY™