Cortland Hearing Aids

PATIENT INFORMATION

Patient's Name: _____ Date: _____

Gender ☐ Male ☐ Female Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Occupation: _____ ☐ Past ☐ Present

Insurance Carrier: _____ I.D. No./Policy No. _____

Marital Status ☐ Single ☐ Married ☐ Widowed Name of Spouse: _____

Name of Observing Party/Appointment Companion (if any): _____ Relationship: _____

Name of Family Physician: _____

Permission to Release a copy of test to Physician upon request? ☐ Yes ☐ No

HEARING HEALTH HISTORY

Do you have any sinus/allergy problems? ☐ Yes ☐ No If yes, please list_____

Are you a diabetic? ☐ Yes ☐ No

Do you have a history of noise exposure? ☐ Yes ☐ No

Do you have any ringing in yours ears? ☐ Yes ☐ No ☐ Left ☐ Right ☐ Both

Do you have any dizziness or loss of balance? ☐ Yes ☐ No If yes, which?

_____

Do you have a family history of hearing loss? ☐ Yes ☐ No

Are you currently taking any medication? ☐ Yes ☐ No If yes, please list

_____

Have you previously had a hearing test? ☐ Yes ☐ No If yes, by whom? _____ Date: _____

Have you received any medical or surgical treatment for a hearing loss? ☐ Yes ☐ No

If yes, what? _____ When? _____ Physician/ENT: _____

Any other medical condition(s)? _____

AMPLIFICATION HISTORY

Do you currently wear hearing aids? ☐ Yes ☐ No Type: _____ ☐ Ear fitted ☐ Both ☐ Left ☐ Right

If yes, what would you like to improve about your current hearing instruments? _____

LIFESTYLE

Please check all that apply: ☐ Listening to Music or ☐ Audiobooks: ☐ Eating out often ☐ Hunting ☐ Watching TV/Movies

☐ Attending Meetings/Conferences ☐ Participating in Sports (please list): _____

☐ Attending sporting events (please list): _____ ☐ Other: _____

How did you hear about us? ☐ Mail ☐ Phone ☐ Newspaper ☐ Yellow Pages ☐ Television ☐ Web ☐ Physician

☐ Patient Referral (their name): _____ ☐ Other: _____