Patient Information Form

Patient Name ____
First MI Last

Preferred Name ____________________ Date of Birth ___/___/_____ Age _______ Gender ◯ Female ◯ Male

Home Phone # ____________________ Cell Phone # ____________________

Work Phone # ____________________ Email ____________________

Mailing Address ____
Street City State Zip Code

How did you hear about us?

◯ Walk-in ◯ DVR ◯ Employer ◯ HLA ◯ Insurance ◯ Mail ◯ Newspaper Ad ◯ Senior Center ◯ Yellow Pages

◯ Lions Club ◯ Assisted Living Facility ____________________ ◯ Online ______________ (website/search engine)

◯ Event ____________________ ◯ Family/Friend/Patient ____________________

◯ Physician/Facility ____________________ ◯ Other ____________________

Employment Status: ◯ Retired ◯ Full-time ◯ Part-time ◯ Unemployed ◯ Student

Occupation/Employer (if **RETIRED**): ____________________

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Long-Term Commitment

Spouse/Partner Name ____________________ Emergency Contact____________________

Phone # ____________________ Relation to Patient ____________________

Primary Care Physician and/or Facility ____________________

Insurance Information: Please let our front office staff know if you have insurance so that we can make a copy for our records.

Assignment and Release: Please read below carefully

I, the Patient or Guardian, certify that the information on this form is true to the best of my knowledge. I authorize Spencer Audiology Clinic to release any information necessary to process an insurance claim on my behalf. I also authorize my insurance benefits to be paid directly to Spencer Audiology Clinic and I understand that I am financially responsible for all charges whether or not paid by my insurance. I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I have read and understand the above information.

Patient Signature ______________________________________ Date ______________

Legal Guardian Signature ______________________________________

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HEARING HISTORY

Name ________________________________ Date ______________

What kind of hearing problems do you have? (Describe specific situations of difficulty regarding your hearing)

When did your hearing loss begin? ______________________

What do you think caused your hearing loss? ______________________

Do you hear better in one ear? ____________ If so, which ear? ________________

Was it a sudden hearing loss or a gradual decrease in hearing? Has your hearing worsened recently? ______________

Do you have problems hearing over the telephone? ◯ Yes ◯ No

Which ear do you use on the telephone? ◯ Right ◯ Left

Have you had ear infections ________, and/or drainage ________? If so, which ear? ____________

Have you ever received medicine or surgery for an ear problem? Describe (include approximate dates):

Have you ever had a skull fracture or concussion? Explain:

Do you have "ringing" or other noises (Tinnitus) in your ears or your head? ◯ Yes ◯ No

If yes, which ear(s)? ◯ Right ◯ Left ◯ Both When is it present? ◯ Constantly ◯ Occasionally ◯ Unsure

When did it begin? ______________________ How long does it last? ______________

Describe what it sounds like to you:

How much does it bother you? (1 = slight, 5 = most severe): ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Do you experience dizziness such as spinning, falling, floating, etc.? ◯ Yes ◯ No

If yes, describe (how often, what causes it, any other associated problems): ______________________

Have you been around noise that may have affected your hearing? ◯ Yes ◯ No

If yes, describe:

Military (artillery, jets, tanks, etc.): ______ Years ______

Work (noisy factory, construction, etc.): ______ Years ______

Recreation (hunting, chain saws, etc.): ______ Years ______

Did/do you use hearing protection consistently? ◯ Yes ◯ No

What kind of hearing protection do you use? ◯ Earplugs ◯ Earmuffs ◯ Both

Is there a history of hearing loss in your family? ◯ Yes ◯ No

If yes, who in your family and what caused their hearing loss? ______

______

Do family members or friends complain about your hearing? ______

Have you had a hearing test before? ◯ Yes ◯ No

Where? ______ When? ______

If known, what were the results? ______

______

Have you ever worn a hearing aid(s)? ◯ Yes ◯ No

If yes, what make are/were your hearing aids? ______

Where obtained: ______ When obtained: ______ Effectiveness: ______

Comments: ______

Do you take medications regularly? ◯ Yes ◯ No

If yes, what medications do you take? ***Please fill out attached medications form.*** ______

Have you ever been given drugs that you were told might affect your hearing or balance? ◯ Yes ◯ No

If yes, what were you given? ______

Check any that you have or had:

◯ Meningitis	◯ Cancer	◯ Macular Degeneration	◯ HIV AIDS
◯ Diabetes	◯ Malaria	◯ Chemotherapy	◯ Vision Problems
◯ Asthma/Lung	◯ Scarlet Fever	◯ High Blood Pressure	◯ Dexterity Difficulties
◯ Cleft Palate	◯ Mumps	◯ Heart Problems	
◯ Head Injuries	◯ Allergies	◯ Hepatitis A B C D	

Comments:

______

Patient or Guardian Signature ______ Date ______

Examiner ______ Date ______

Companion Questionnaire

SPENCER AUDIOLOGY CLINIC

If your companion does not currently use technology, please skip this section.

My companion has difficulty hearing when using technology...	Always	Sometimes	Never	N/A
1. While in background noise	◯	◯	◯	◯
2. In the car	◯	◯	◯	◯
3. On the phone	◯	◯	◯	◯
4. In a conference room	◯	◯	◯	◯
5. In a restaurant	◯	◯	◯	◯
6. While listening to music	◯	◯	◯	◯
7. While watching TV	◯	◯	◯	◯
8. In group conversations	◯	◯	◯	◯
9. In conversations with their spouse or family	◯	◯	◯	◯
10. In conversations with women or children	◯	◯	◯	◯

Additional comments: ____

Medication Documentation

SPENCER AUDIOLOGY CLINIC

In order for us to provide the best healthcare, it is important for us to know the medications you are taking. Please fill out this form and bring with you to your appointment.

Below, please list each medication you are currently taking including the following: prescriptions, over-the-counter medicine, herbals and vitamin/mineral/dietary supplements.

Medication Name	Dosage	Frequency	Oral, shots, dermal, etc	Condition it is Treating

Patient or Guardian Signature ______________________________ Date ____________