



PATIENT INTAKE FORM

Patient ID: _____ FOR OFFICE USE ONLY Date: ____/____/____

Name: _____ (First) (MI) (Last)

Date of Birth: ____/____/____ Age: _____ Gender: M F

Primary Resident Information

Address: _____ (Street) (City)

Telephone: _____ Occupation: _____

General Information

Next of Kin: _____ Daytime Telephone: _____

Primary Care Physician: _____

Do you have pain/discomfort in your ear(s)? Yes: ___ No: ___
Do you have any drainage in your ear(s)? Yes: ___ No: ___
Have you had a sudden or rapid loss of hearing in the past 90 days? Yes: ___ No: ___
Do you have ringing or other noises in your ear(s)? Yes: ___ No: ___
Do you have acute or recurring dizziness or vertigo? Yes: ___ No: ___
Have you seen your physician regarding any of the above? If so, when? _____
Have you ever had ear surgery? Yes: ___ No: ___

Hearing History:

When was the first time you noticed difficulty hearing? _____
Have you had your hearing tested before? Yes: ___ No: ___ When: _____ Results: _____
In which ear is your hearing the worst? Right: ___ Left: ___ Same: ___
Have you noticed that people seem to mumble? Yes: ___ No: ___
Do you find yourself asking people to repeat what they have said? Yes: ___ No: ___
Do you sometimes hear words but do not always understand them? Yes: ___ No: ___
Do you find it difficult to hear in noisy places? Yes: ___ No: ___
Have you been told that you speak loudly? Yes: ___ No: ___
Have you been told that you turn the volume on TV up too loud? Yes: ___ No: ___
Do you have strain to understand young children's voices? Yes: ___ No: ___

I certify that the above information is correct and that I have read and fully understand the above statements.

Authorized Signature _____ Date: ____/____/20__