PATIENT INTAKE FORM

PATIENT INFORMATION

Last Name ______________________________ First Name ________________________________ MI_____

Address ____

City ________________________________ State ____ Zip _________ Home (_____) ________________

Email ____ Cell (_____) ____________________

Date of Birth __________________ Age ______ Past/Present Occupation____________________________

Insurance Carrier ____ ID # ______________________________

How did you hear about us? ☐ Newspaper ☐ Mail ☐ Website ☐ Friend ☐ Physician ☐ Other________

Family Physician _________________________________ Permission to send test to physician ☐ Yes ☐ No

Patient Signature ______________________________________ Today's Date ______________________

HEALTH HISTORY

Do you have any allergies? ☐ Yes ☐ No If yes, list ____

Please list your medications: ____

Are you taking any blood thinners? ☐ Yes ☐ No Do you have rheumatoid arthritis? ☐ Yes ☐ No

Are you a diabetic? ☐ Yes ☐ No Which is your poorer ear? ☐ Left ☐ Right ☐ Same

Please list any other health issues you have: ____

Have you ever had ear surgery or medical treatment for your ears? ☐ Yes ☐ No Explain _______________

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Have you had a **sudden** loss of hearing in the last 90 days? ☐ Yes ☐ No Which ear? _________________

Do you have pain in your ears? ☐ Yes ☐ No Have you seen a doctor for wax removal? ☐ Yes ☐ No

Do you have ringing in your ears? ☐ Yes ☐ No Which ear? ☐ Left ☐ Right ☐ Both

Have you had drainage from your ears in the past 90 days? ☐ Yes ☐ No

Do you have dizziness? ☐ Yes ☐ No Explain ____

Who in your family has/had hearing loss? ____

Have you **ever** been exposed to loud noises? ☐ Yes ☐ No If yes, explain __________________________