Hearing Healthcare Center
3101 N. Green River Rd., Ste 620
Evansville, IN 47715
812.303.4300

Date: ___/____/_____

PLEASE PRINT CLEARLY

Name: _____ Birth date: _____Age: _____

Primary address: _____
Street City State Zip

Home phone: ( )_____Cell phone: ( ) _____

Email address:_____Primary physician: _____
For appointment confirmation or changes, provider communication, practice updates, etc.

Sex: ☐ Male ☐ Female Marital status: ☐ Single ☐ Married ☐ Widowed ☐ Other _____

Emergency contact:_____ Phone: ( ) _____

Relationship to patient:_____

1. What is your primary complaint with your ears and/or hearing? _____

   _____

   When did you first notice this? _____
2. Have you sought help for your hearing within the past 12 months? ☐ Yes ☐ No

   If yes, explain:_____
3. From which ear do you hear better? ☐ Right ☐ Left ☐ Both the same
4. Does your hearing change from time to time? ☐ Yes ☐ No
5. Do loved ones or friends comment about your hearing? ☐ Yes ☐ No If yes, explain: _____
6. Have you been exposed to loud noises recently or in the past? ☐ Yes ☐ No
7. Are you dizzy at times or do you have balance problems? ☐ Yes ☐ No

   If yes, please describe your symptoms. _____

Do you have…	Right	Y/N	Left	Y/N	(For Hearing Professional Only)
Ear pain?					
Ear drainage?					
Fullness in the ears?					
Ringing in the ears?					

Please check all that apply:

☐ Stroke ☐ Heart attack ☐ Pacemaker ☐ Visual problems

☐ Arthritis ☐ Head injury ☐ Aspirin therapy ☐ Diabetes ☐ High blood pressure

☐ Ear infections or surgeries (include date): _____

☐ Other medical conditions: _____

Additional information - for office use only

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Hello and welcome!

To achieve the most out of your visit today, we want to first understand your daily activities and your goals for hearing better. Secondly, we'll perform a hearing test to assess your hearing ability. Lastly, we'll pull all this information together and discuss a plan to help you achieve your goals.
Please fill out the information below and be as detailed as possible.

What motivated you to set the appointment for today's hearing test?_____

_____

What is your hearing aid experience?

- ☐ I use hearing aid(s) regularly
- ☐ I have hearing aids but rarely use them
- ☐ I have never used hearing aids
- ☐ I had my hearing tested at another office but never tried wearing hearing aids
- ☐ I once tried hearing aids but with no success

Please see the lifestyle settings below and note specific situations where you'd like to hear better. For example, "hearing my friends better in a restaurant." We will then explore these with you during your appointment.

1. Hearing with family, friends and at social settings: _____

_____

_____

_____

2. Hearing at home and during everyday activities: _____

_____

_____

_____

3. Hearing in the workplace: _____

_____

_____

_____

Please note any questions about hearing loss or hearing aids you would like to discuss today: _____

_____

_____

_____