PATIENT INTAKE FORM

Client History

Today's Date _______________

Last Name __________________________ First Name ________________________ MI ___

Address _________________________________ City __________________________ State _____
Zip Code ______________

Phone _________________ Alternate Phone ___________________ Email address _______________________

Date of Birth __________ ☐ Male ☐ Female ☐ Married ☐ Single ☐Widow(er)

Past/Present Occupation ____

Accompanying Party ____________________________ Relationship to Patient _______________

Referring Physician Name ____

How did you hear about us? ____

Medical and Hearing Health History

Do you have any of the following:

Deformity of the ear?	☐ YES	☐ NO
Sudden or rapid hearing loss in the past 90 days?	☐ YES	☐ NO
Pain of discomfort in the ear?	☐ YES	☐ NO
Acute or recurring dizziness?	☐ YES	☐ NO
Previous ear infections?	☐ YES	☐ NO
Active drainage from the ear?	☐ YES	☐ NO

Have you ever found it necessary to have a doctor remove wax from your ear? ☐ YES ☐ NO

In which ear do you feel you are hearing the worst? ☐ BOTH ☐ LEFT ☐ RIGHT

Medical and Hearing Health History (continued)

Do you have any sinus or allergy problems? ☐ **YES** ☐ **NO**
If YES, please list: ____

Are you a diabetic? ☐ **YES** ☐ **NO**
If YES, are you insulin-dependent? ☐ **YES** ☐ **NO**

Have you ever been exposed to excessive loud noise? ☐ **YES** ☐ **NO**

Do you have a history of firearm use? ☐ **YES** ☐ **NO**

Do you have ringing or other noises in your ears? ☐ **YES** ☐ **NO**
If YES, which ear? _________________________

Have you ever had your hearing tested? ☐ **YES** ☐ **NO**
If YES, by whom and when? ____

Have you ever received any medical or surgical treatment for your ears or hearing loss? ☐ **YES** ☐ **NO**
If YES, explain and include dates if possible ____
____

Please list any medications you are currently taking here or provide a copy of a list ________________________
____
____

Amplification History

Do you currently wear any amplification device? ☐ **YES** ☐ **NO**

If YES, what type? ___________________ **Ear fitted:** ☐ **BOTH** ☐ **LEFT** ☐ **RIGHT**

If YES, and you could improve something about your current device, what would that be?
____

____

Do you know anyone who wears hearings aids? ☐ **YES** ☐ **NO**

If YES, who? _____________________________

Is there anything else you would like Dr. Spector to know about yourself or medical history that was not included on this form? ____

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