ADVANCED
AUDIOLOGY CARE

Patient Intake Form

Name_____ Date of Birth_____ Today's Date_____

Please complete the following questions, as it will help us determine the most appropriate and personalized hearing care for you, based on your medical, hearing, and social history.
Thank you for your time!

HEARING

What is your primary reason for today's visit? _____

Do you think you have hearing loss? __Yes __No
If yes, **for how long** have you been aware of your hearing loss? _____
Was your hearing loss **sudden or gradual**? _____

Do you hear better from one ear compared to the other? __Yes __No
If yes, which is the better ear? __Right __Left
Which ear is worse? ___Right ___Left

Do you have a **family history of hearing loss**? __Yes __No

Do you have a history of **noise exposure**? __Yes __No
If yes, please describe. Work, military, or recreational? _____

Have you ever been evaluated by an audiologist or ENT? ___Yes ___No
If yes, please explain_____
Name of doctor_____ Date of evaluation_____

Please list two situations in which you would like to improve your hearing:

1._____

2._____

In which situations do you have **difficulty hearing**? Please check all that apply.

___When speaking with one individual person
___ In a small group (small dinner party, playing cards)
___ In a large group (meetings, conferences, church or synagogue)
___ On the telephone
___ In a noisy environment (parties, restaurants)
___ Communicating with colleagues, clients, or employees at work
___ In the car
___ TV (Do you use captions?) _____
___Other (Please explain) _____

MEDICAL HISTORY

Do you have a history of any of the following? Please check all that apply:

____Ear infections
____Ear, Nose, or Throat surgery Please describe_____
____Ear Pain or Discomfort
____Ear Drainage
____Ear Fullness / Pressure
____Tinnitus (ringing /noises in your ears or head)
____Dizziness or Vertigo
____Excessive Ear Wax

Do you have a history of any of the following medical conditions (Please check all that apply)

____Heart condition	____Pacemaker	____Diabetes
____Kidney disease	____Vision loss	____High blood pressure
____High cholesterol	____Head trauma or Injury	____Migraines
____Peripheral Neuropathy	____Numbness on your face	____Measles or Mumps
____Meningitis	____CMV	____Sinusitis
____Meniere's Disease	____Multiple sclerosis	____HIV or AIDS
____Hepatitis	____Bell's Palsy	____Parkinson's Disease
____Stroke /TIA	____Dementia	____Neurological Disorders
____MRI or CT of the head	____Anxiety/Depression	____Arthritis
____Liver disease	____Thyroid disease	____Allergies/Asthma
____Osteoporosis	____Cancer	____Chemotherapy
____Tingling or numbness in your hands or fingers		____Other: _____

Please list your current **medications** (or provide a copy of your medication list):

Medication _____ Reason_____

Medication _____ Reason_____

Medication _____ Reason_____

ALLERGIES

Please list any **allergies** to medications or foods_____

Are you allergic to latex gloves? __Yes __No

SURGICAL HISTORY

Please list any previous **surgeries** or **hospitalizations**? _____

_____

SOCIAL INFORMATION

Occupation_____ Hobbies_____

Tobacco Use: Do you smoke? ____Yes ____No

Alcohol Use: Do you drink alcohol? _____ How many drinks per week? _____

Do you exercise? _____ How often? _____

Do you consume caffeinated products? _____

Have you recently noticed an increase in sadness or gloominess? _____Yes _____No

Have you lost interest in enjoyable activities? _____Yes _____No

HEARING AIDS

Do you currently wear hearing aids? ____Yes _____No

Please rank these factors in order of importance (1 being most important, 4 being least important):

___Hearing in Quiet ___Hearing in Noise ___Hearing Aid Expense ____Cosmetics

If today's test results show that hearing aids would be beneficial, how ready are you to try amplification. Please rate your readiness on a scale of 1-10:

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

For current hearing aid users only:

Do you wear one hearing aid or two? _____
How long have you worn hearing aids? _____
Make and model of your current hearing aids_____
How old are your current hearing aids? _____
How often do you wear your hearing aids? _____
What would you like to improve about your current hearing aids? _____

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NOTICE OF PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

- Conduct, plan and direct my treatment and follow-ups among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations.

_____ _____

Printed Name of Patient or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative Date

I hereby give permission to Advanced Audiology Care to send follow-up letters, promotional offers, and new product information/newsletters to my Email address or physical address.

Please circle **Yes** or **No**