

Confidential Record Form

Date: _____

Name: _____ Male Female

LAST FIRST INITIAL

Married Single Widow(er) Spouses Name _____ Accompanied by: _____

Permanent Address: _____
STREET CITY STATE ZIP

Seasonal Address (if applicable): _____
STREET CITY STATE ZIP

Occupation: Retired Part-Time Full Time Description _____

Home Phone: _____ Birthdate: _____ Age: _____

Cell Phone: _____ Email Address: _____

Family Physician Name: _____

Emergency Contact: _____
NAME RELATION PHONE

Address: _____
STREET CITY STATE ZIP

Previous Provider: _____

Have you ever been here before?..... Yes No

Do you know anyone who has been here..... Yes No

if YES, list names _____

Referral Source (check one):

- Doctor Referral Customer Referral Friend/Family Newspaper Mail
- TV Website Yellow Pages Store Sign Walk in
- Other _____

Medical/Hearing History

Any Blood Thinner Yes No

Do you experience ringing in your ears? Yes No

When did you first notice that you were having difficulty with your hearing? _____

In which ear do you have greater difficulty hearing _____ Right Left Same

What do you believe caused your hearing loss? _____

Have you ever had a hearing evaluation? Yes No

If so when and where was your most recent exam? _____

Was anything recommended as a result of this evaluation? _____

Have you received any medical or surgical treatment for a hearing loss?..... Yes No

Amplification History

Have you worn hearing aids in the past? Yes No

Type: _____

Do you currently wear hearing aids? Yes No

Type: _____

If yes, and you could improve 2-3 things about your current hearing instrument, what would they be? _____

Financial Hearing Instrument Priorities

If hearing loss is discovered, are you ready for help?..... Yes No

If YES, are you interested in applying for our financing?..... Yes No

If we find during our evaluation that you can be helped with hearing instruments, which of the following would be most important to you? Please number 1-4 in the order of importance, with 1 being the most important and 4 being the least important.

- Understanding Speech Size: inconspicuous appearance Cost Hearing in noisy surroundings

FDA Questions

- Visible congenital or traumatic deformity of the ears? Yes No
- Any history of, or active drainage from, the ear with in the previous 90 days? Yes No
- Any history of sudden or rapidly progressive hearing loss with the previous 90 days? Yes No
- Have you experienced any acute or chronic dizziness? Yes No
- Is there a unilateral hearing loss of sudden or recent onset within the previous 90days? Yes No
- Have you experienced any pain or discomfort? Yes No

Healthcare Professional Use Only

- Visible evidence of significant cerumen accumulation of a foreign body in the ear canal? Yes No
- Audiometric air-bone gap equal to, or greater than, 15db at 500 Hz, 1000 Hz, 2000 Hz? Yes No

Representative _____ License # _____

Communication Profile

*How? When? Tell me more! Help me understand! Give me an example. I understand.
(To be discussed with customer and companion)*

Who encouraged you to come in day to see a hearing professional? _____

What sort of things have others said or noticed about your level of communication with them? _____

What sort of things have you noticed about your level of communication with others? _____

How does this difficulty with communication concern others? _____

How does this difficulty with communication concern you? _____

If I can help you communicate more effectively in your specific listening environment and especially in your #1 priority environment, is that the result that you are looking for today? _____