

ASPEN HEARING CENTER

PATIENT DATA

(Please Print)

NAME: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE #: _____ WORK PHONE #: _____

MOBILE PHONE/PAGER #: _____ EMAIL: _____

BIRTHDATE: ____/____/____ AGE: _____ (Please Circle One): MALE

FEMALE

MARITAL STATUS: _____ EMPLOYER: _____

SOCIAL SECURITY NUMBER: _____

PRIMARY CARE OR REFERING PHYSICIAN: _____

PRIMARY INSURANCE CARRIER: _____

SECONDARY INSURANCE CARRIER: _____

REFERRAL SOURCE (check one):

Doctor Referral Customer Referral Friend/Family Newspaper Mail Yellow Pages

Walk-In Magazine Ad Other: _____

MEDICAL/AUDIOLOGICAL INFO

Please list conditions for which you are being medically treated: _____

Please list all medications taken regularly: _____

History of ear infections	YES	NO	_____
Surgery on your ear	YES	NO	_____
Sudden hearing loss	YES	NO	_____
Ear difference (one better than other)	YES	NO	_____
Tinnitus (ringing/buzzing in ears)	YES	NO	_____
Vertigo/Dizziness	YES	NO	_____
Ear pain or drainage	YES	NO	_____
Family history of hearing loss	YES	NO	_____
History of noise exposure	YES	NO	_____
Chemotherapy/Radiation	YES	NO	_____
Head/Neck trauma or injury	YES	NO	_____
Prior hearing aid use	YES	NO	_____

COMMUNICATION DIFFICULTIES

I notice hearing problems	YES	NO	_____
My family notices hearing problems	YES	NO	_____
I have difficulty with the telephone	YES	NO	_____
I have difficulty with the television	YES	NO	_____
I have difficulty in groups/crowds	YES	NO	_____
Do you hear certain voices/pitches better than others?	YES	NO	_____
Do you avoid social situations because of your hearing problems?	YES	NO	_____