Medical Hearing History

Louisville Family Audiology &
Hearing Aid Center
4003 Kresge Way, Suite 225
Louisville, KY 40207
Phone: (502) 893-3342
Fax: (502) 893-3343

Date:_____

Demographics

Patient's Name: _____ Date of Birth: _____

Address: _____

City/State: _____ Zip:_____ Home Phone:_____

Cell Phone: _____ Emergency Contact:_____

Relationship to Emergency Contact:_____Emergency Contact Phone: _____

Primary Care Physician (PCP): _____ PCP Phone: _____

How did you hear about us? _____

Insurance Information

Health Insurance: _____ Policy #:_____ Phone:_____

Health Insurance Policy Holder: _____ Policy Holder DOB: _____

History

1.	What is your reason for this visit? _____	
2.	Difficulty hearing?	YES / NO
3.	Do you have a family history of hearing loss?	YES / NO
4.	Do you have ringing or other noises in your ears? (e.g. buzzing, chirping pulsing, static noise, music, etc.)	YES / NO
5.	Do you feel that you hear but do not always understand the words?	YES / NO
6.	Do you have trouble hearing in crowds or other noisy situations?	YES / NO
7.	Do you ever, or have you ever worked around loud noise?	YES / NO
8.	Do you have any noisy hobbies?	YES / NO
9.	Do you or have you ever experienced dizziness or balance problems?	YES / NO
10.	Did your hearing problem progress slowly or was it sudden?	SLOWLY / SUDDEN
11.	Do you suffer or have you suffered from repeated ear infections?	YES / NO
12.	Do you have any fullness or pressure in your ears	YES / NO
13.	Have you ever had ear surgery?	YES / NO

14. Do you have history of wax buildup? YES / NO

15. Have you ever worn hearing aids? YES / NO

16. Do you have trouble hearing in any of the following situations? (Check all that apply)

___TV ___Family Members ___ Work ___ Worship ___Phone ___ Social Gatherings ___ Restaurants ___Meetings ___

Other: _____

_____

17. Check any of the following medical conditions that apply:

___ Autoimmune Disorder ___ Blood thinner ___ Chemotherapy ___ Arthritis

___ Stroke or head injury ___ Implantable devices ___ Radiation to head or neck ___ Diabetes

___Dementia ___ Other: _____

18. Please list any medications you are now taking: _____

_____

_____

Acknowledgement of Privacy Practices

Please read and **INITIAL** below:

____ I certify that the information on this sheet is true and correct to the best of my knowledge. I give Louisville Family Audiology & Hearing Aid Center, LLC permission to evaluate me.

____ I acknowledge that I have read a copy of Louisville Family Audiology & Hearing Aid Center, LLC. -OR- Louisville Family Audiology & Hearing Aid Center, LLC offered me a copy of their Privacy Practices and I declined the offer.

____ I give Louisville Family Audiology & Hearing Aid Center, LLC permission to contact me by telephone, email, and regular mail regarding appointment information, hearing health issues, hearing instruments, and technology. Occasionally, Louisville Family Audiology & Hearing Aid Center, LLC may contact me regarding marketing for the organization. I understand that I may opt out of communications for marketing at any time. I know that my personal information will not be shared with any other entity.

____ I give Louisville Family Audiology & Hearing Aid Center, LLC permission to leave messages and/or disclose my hearing healthcare information and/or services with the following people (please name):

____ Answering Machine/Voice Mail

____ Spouse: _____

____ Adult Children: _____

____ Care Giver: _____

____ Other: _____

Signature: _____ **Date:**_____

Print name: _____ **Relationship to Patient**: _____