Queen City Audiology

NEW PATIENT INFO

NAME: **DOB**: **GENDER**:

ADDRESS:

OCCUPATION: **PHONE**:

HEALTH INSURANCE: **REFERRAL SOURCE:**

EMAIL (optional):

HEARING HISTORY

Do you have difficulty *hearing* or *understanding* speech?

In what situations do you have the most difficulty?

Onset date: Was onset *sudden* OR *gradual*?

Do others complain about your hearing? Have you ever worn *hearing aids*?

Date of most recent *hearing test*:

MEDICAL HISTORY

Do you experience any of the following? ***If yes, please specify frequency and severity.***

Ear *pain*?

Pressure or "blocked"/"plugged" feeling in the ear(s)?

Spinning sensation?

Noise in the ears/head ("ringing", "buzzing" or any other sounds)?

Other chronic health conditions (*diabetes*, *neuropathy*, *vision problems*, etc...)?

NOISE HISTORY- please provide details if ever exposed to the following:

Occupational noise (*construction, warehouse, factory, farm equipment, etc...)*?

Hazardous *military* noise? MOS/AFSC/job title?

Recreational noise (*firearms*, *motorcycles*, *woodworking tools*, *musician,* etc...)?

Details of noise history:

I consent to hearing assessment and treatment by Queen City Audiology. I am aware of this practice's Privacy Policy (i.e. HIPAA), available at www.queencityhearing.com; hard copy available in office.

Signature: ***Date:***

Please bring **INSURANCE CARD** to your first visit. Thank you!