PATIENT INTAKE FORM

DATE: ______________________

PATIENT HISTORY

LEGAL NAME: ____

NICKNAME: __________________________________ DATE OF BIRTH: ___________________________________

MAILING ADDRESS: ____

CITY: ____ STATE: _________________ ZIPCODE: ________________

TELEPHONE: HOME________________________________ CELL: ___________________________________

EMAIL: ____

WINTER RESIDENT? YES NO WINTER ADDRESS: ____

CITY: ____ STATE: ___________________ ZIPCODE: _________________

MARTIAL STATUS: ______________________ NAME OF SPOUSE: ____

PAST/PRESENT OCCUPATION: ____

HOW DID YOU HEAR ABOUT US? (Please circle)

REFERRAL NEWSPAPER MAILER INTERNET OTHER: _______________________________

MEDICAL AND HEARING HISTORY

FAMILY PHYSICIAN NAME: ____

HAVE YOU EVER HAD ANY TYPE OF EAR SURGERY?	YES	NO	
SUDDEN OR RAPID HEARING LOSS IN THE PAST 90 DAYS?	YES	NO	
PAIN OR DISCOMFORT IN THE EARS?	YES	NO	SOMETIMES
ANY DIZZINESS OR VERTIGO?	YES	NO	SOMETIMES
ACTIVE DRAINAGE FROM THE EARS?	YES	NO	SOMETIMES
WHICH IS YOUR POORER EAR?	LEFT	RIGHT	SAME
ANYONE IN YOUR FAMILY HAVE A HEARING LOSS?	YES	NO	
DO YOU SUFFER FROM ALLERGIES?	YES	NO	SOMETIMES
DO YOU HAVE RINGING IN YOUR EARS?	YES	NO	SOMETIMES
HAVE YOU EVER HAD YOUR HEARING TESTED?	YES	NO	

DATE OF LAST HEARING TEST? _________________________

ON A SCALE FROM 1-10(10 BEING EXCELLENT) HOW WOULD YOU RATE YOUR OVERALL HEARING?

1 2 3 4 5 6 7 8 9 10

DO YOU EXPERIENCE DIFFICULTY HEARING AND/OR UNDERSTANDING?

WOMEN AND CHILDREN MORE SO THEN MEN	YES	NO	SOMETIMES
IN A RESTAURANT	YES	NO	SOMETIMES
ON THE TELEPHONE	YES	NO	SOMETIMES
TV OR RADIO	YES	NO	SOMETIMES
AT CHURCH	YES	NO	SOMETIMES
HAVE YOU EVER WORN A HEARING AID?	YES	NO	

EAR FITTED (Please circle): LEFT RIGHT BOTH HOW MANY YEARS WORN? ____________

IF YES, WHAT WOULD YOU LIKE TO IMPROVE ABOUT YOUR CURRENT SET OF HEARING AIDS

____

____

____

SCALE FROM 1 TO 4 REGARDING HEARING DEVICES WHAT IS MORE IMPORTANT TO YOU:

_________UNDERSTANDING FAMILY AND FRIENDS	1- MOST IMPORTANT
_________HEARING DEVICE APPEARANCE AND SIZE	2- SOME WHAT IMPORTANT
_________SERVICE	3- LEAST IMPORTANT
_________COST OF HEARING DEVICES	4- NOT IMPORTANT

THANK YOU FOR CHOOSING BELTONE FOR YOUR HEARING HEALTHCARE

PATIENT SIGNATURE: ____**DATE:**_______________________

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Helping the world hear better