PATIENT HISTORY

Today's Date ___________

PERSONAL

Name____

Gender: ☐ Male ☐ Female ☐ Other ___________

Date of Birth ___________

Address ____

City ____

State __________________ Zip ______________

Phone: Home ______________ Cell ______________

Email ____

Marital Status:

☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of spouse, if applicable _________________

Employment Status:

☐ Part-Time ☐ Full-Time ☐ Retired ☐ Student

Occupation *(current or former)* ____________________

Guardian Name ____________________________
(If applicable)

Do guardian and patient have same phone number?

☐ Yes ☐ No, please list ________________________

Primary Insurance:

Primary Insurance Co. ______________ ID# ______________

Name of Policy Holder ______________ Policy Holder DOB ______________

Secondary Insurance:

Primary Insurance Co. ______________ ID# ______________

Name of Policy Holder ______________ Policy Holder DOB ______________

MEDICAL HISTORY

Primary Care Physician ________________________

Phone ____

Address ______________________________________

Have you seen a physician specializing in diseases of the ear?..........................☐ Yes......☐ No

If yes, when______ Name ___________________

Have you ever been treated by a physician for your hearing or ear problems?..........☐ Yes......☐ No

If yes, describe: ______________________________

Have you ever had any type of ear surgery?...☐ Yes......☐ No

If yes, describe: ______________________________

Medical History/Conditions *(Check all that apply)*

☐ Vision difficulty ☐ Ringing in the ears/head noises

☐ Pacemaker ☐ Blood thinner use

Are you being treated for any of the following?

☐ High blood pressure ☐ Thyroid problems

☐ Diabetes

Please list:

Medications you are taking:___________________

____

Serious illnesses/major surgeries within 10 years:

____

____

____

HEARING HISTORY

How long have you had hearing difficulties?

☐ Less than a year ☐ 2-5 years ☐ 10 years+

☐ 1-2 years ☐ 5-10 years

Have you ever had a hearing test? .....☐ Yes....☐ No

If yes, when and by whom? ___________________

Do you wear hearing instruments? ....☐ Yes....☐ No

If yes, how long? _____________________________

Which ear do you use on the phone? ____________

Have you ever worked in noise? ....☐ Yes....☐ No

If yes, describe ______________________________

Does anyone in your family have trouble with their hearing?...............................☐ Yes....☐ No

If yes, how are you related? ___________________

Does your hearing cause you difficulty...

When listening to TV or radio? ....☐ Yes....☐ No

When attending religious (or similar) functions?..........................☐ Yes....☐ No

Understanding voices in background noise?...............................☐ Yes....☐ No

When talking with your spouse or other family members? ....☐ Yes....☐ No

When you're on the phone? ....☐ Yes....☐ No

Please describe any other hearing/communication difficulties you are experiencing: ______________

____

____

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Patient Name ______________________________ Person Observing ____________________
First/Middle/Last

Exam Date ___________

Clinician ______________________

License/Cert. # __________________

Results Of Otoscopy

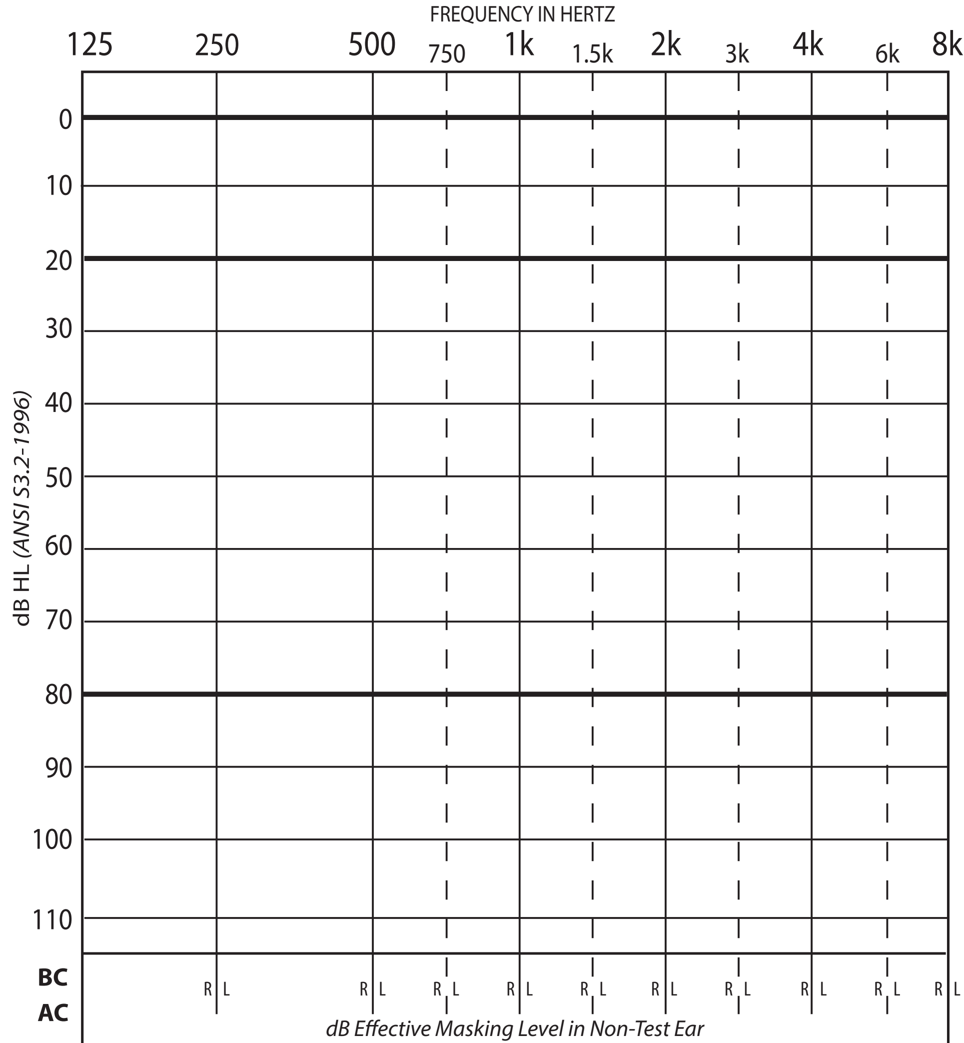
	Right	Left
No Blockage	☐	☐
Partially Blocked/Impression OK	☐	☐
Canal Blocked	☐	☐

Sound Presentation & Test Information

☐ TDH Headphones ☐ Insert Earphones

Audiometer S/N ____________________

Calibration Date ____________________



Acoustic Reflex Ipsilat/Contralat					
Ear	500	1k	2k	4k	BBN
Right	/	/	/	/	/
Left	/	/	/	/	/

Loudness Discomfort Level Tones (dB HL)					
Ear	500	1k	2k	3k	4k
Right					
Left					

Ear	PTA	SRT/SDT	UCL	MCL	WRS	Presentation Level
Right					%	☐ MCL ☐ Masking Level _____ dB
Left					%	☐ MCL ☐ Masking Level _____ dB
Binaural				R | L	%	☐ MCL

Audiogram Key		Right Ear	Left Ear	*NO* Response Right Ear	*NO* Response Left Ear
Air Conduction	Unmasked	O—O	X—X	O↙	X↘
	Masked	△—△	□—□	△↙	□↘
Bone Conduction	Unmasked	<·····<	>·····>	<↙	>↘
	Masked	[·····[	]·····]	[↙	]↘

Comments: ____

	Right Ear			Left Ear		
	Volume (ml)	Pressure (daPa)	Compliance (ml)	Volume (ml)	Pressure (daPa)	Compliance (ml)
Tympanometry						
Acoustic Reflex Decay						
Otoacoustic Emmissions						

HearingLife

Patient Name ____________________
First/Middle/Last

FDA Red Flags

	Yes	No
Visible congenital or traumatic deformity of the ear.	☐	☐
History of active drainage from the ear within the previous 90 days.	☐	☐
History of sudden or rapidly progressive hearing loss within the previous 90 days.	☐	☐
Acute or chronic dizziness.	☐	☐
Unilateral hearing loss of sudden or recent onset within the previous 90 days.	☐	☐
Audiometric air-bone gap equal to or greater than 15 decibels at 500 Hertz (Hz), 1,000 Hz, and 2,000 Hz.	☐	☐
Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.	☐	☐
Pain or discomfort in the ear.	☐	☐

Sound Field

High Frequency List
California Consonant Test

Live Voice

☐ Unaided ☐ Aided ☐ Noise ☐ Quiet		☐ Unaided ☐ Aided ☐ Noise ☐ Quiet	
gage		tore	
pail		rage	
cup		pill	
mush		chop	
face		muss	
kill		dale	
leap		peach	
seep		rap	
fake		have	
babe		tick	
pays		share	
kick		beak	
laugh		beal	
cheap		chip	
gaze		cuff	
beep		kick	
mass		tin	
patch		bus	
gave		date	
thick		lass	
shin		hitch	
much		sick	
reap		leaf	
back		cheat	
same		ridge	
Number Correct x 4		**Number Correct x 4**	

Word Recognition

25 words per ear required unless first 10 are 90% correct.

NU6 LIST 1-A

☐ Live Voice ☐ Recorded

☐ TDH Headphones ☐ Insert Earphones ☐ R ☐ L ☐ Binaural ☐ Noise ☐ Quiet **Levels in dB HL** Presentation / Masking		☐ TDH Headphones ☐ Insert Earphones ☐ R ☐ L ☐ Binaural ☐ Noise ☐ Quiet **Levels in dB HL** Presentation / Masking	
laud		love	
boat		sure	
pool		knock	
nag		choice	
limb		hash	
shout		lot	
sub		raid	
vine		hurl	
dime		moon	
goose		page	
whip		yes	
tough		reach	
puff		king	
keen		home	
death		rag	
sell		which	
take		week	
fall		size	
raise		mode	
third		bean	
gap		tip	
fat		chalk	
met		jail	
jar		burn	
door		kite	
Number Correct x 4		**Number Correct x 4**	

NU6 LIST 2-A

☐ Live Voice ☐ Recorded

☐ TDH Headphones ☐ Insert Earphones ☐ R ☐ L ☐ Binaural ☐ Noise ☐ Quiet **Levels in dB HL** Presentation / Masking		☐ TDH Headphones ☐ Insert Earphones ☐ R ☐ L ☐ Binaural ☐ Noise ☐ Quiet **Levels in dB HL** Presentation / Masking	
pick		mill	
room		hush	
nice		shack	
said		read	
fail		rot	
south		hate	
white		live	
keep		book	
dead		voice	
loaf		gaze	
dab		pad	
numb		thought	
juice		bought	
chief		turn	
merge		chair	
wag		lore	
rain		bite	
witch		haze	
soap		match	
young		learn	
ton		shawl	
keg		deep	
calm		gin	
tool		goal	
pike		far	
Number Correct x 4		**Number Correct x 4**	

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Acknowledgment of Receipt of Privacy Practices Notice

By signing this form, you acknowledge receipt of the Notice of Privacy Practices from our company. The Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to review it carefully. The Notice of Privacy Practices is subject to change. If the Notice is changed, you may obtain a revised copy by contacting us at the address below.

I acknowledge receipt of the Notice of Privacy Practices from your company.

____ ________________

Patient Signature *Date*

Office Use Only

We attempted to obtain the patient's signature to acknowledge receipt of our *Privacy Practices Notice*, but were unable to do so. HIPAA laws require we keep record of attempt to obtain acknowledgment.

Date_______________ Initials __________________ Reason: ________________________________

____

RECORD OF ACKNOWLEDGMENT TO REMAIN IN PATIENT FILES AT ALL TIMES

Consent to Telephone Contact

I hereby give my consent for your company, or entities calling on its behalf, to call my home or other alternative locations and leave a message on voice mail or in person in reference to carrying out treatment, payment or operational activities such as appointment reminders, insurance items and any calls pertaining to my hearing health care.

This permission shall remain in effect as long as I have not revoked my consent in writing and asked to be placed your do-not-call list. Signing this form does NOT obligate me to make any purchases or otherwise respond to calls from your company.

____ ________________

Patient Signature *Date*

Please fill in the phone number(s) we have your permission to use to contact you.

Home Phone ________________________________ **Cell Phone** _________________________________

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