Intake Form

Patient Name _____ Date of Birth _____
First Last MI

Address _____
Street City State Zip

Home Phone _____ Cell Phone _____

Email _____

Sex ☐ M ☐ F Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Other _____

Emergency Contact _____ Phone _____ Relationship to Patient _____

Primary Care Physician _____ Phone _____

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient _____
☐ Advertisement ☐ Insurance ☐ Referred by Physician _____
☐ Consumer Seminar ☐ Employer ☐ Other _____

☐ I give permission to receive newsletters or information about upcoming events and articles pertaining to services or products in the clinic.

University Clinic Disclosure

- Clinical services are provided by clinical teams. Each team is composed of a clinical faculty/instructor, graduate student clinician(s) and other consultative faculty as needed.
  - All clinical faculty/instructors hold a valid CA license and are experienced audiologists. Clinical faculty/instructors are directly responsible for patient care and supervision.
- Graduate student clinicians may observe and assist in patient appointments for educational purposes.
- Services may be observed by visual and/or electronic means and/or audio and video recordings to be used by the student clinician and clinical faculty/instructor in the development of diagnostic/treatment plans. Audio/video recordings may be used for educational purposes in the classroom. Confidentiality of all information will be honored and HIPAA guidelines followed.

I have read all the information on this form, agree to the checked boxes above, certify this information is true and correct to the best of my knowledge and hereby give my permission to the practice to treat my concerns.

_____ _____
Patient Signature Date

_____ _____
Legal Guardian if Patient is a Minor Date

Medical History

When was your last hearing exam? _____ By whom? _____

How much of a problem is hearing? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How much of a problem is tinnitus (ringing in the ears)? ☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 6–10 Years ☐ 10+ Years

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No
If yes, when? _____ Which ear? _____ Name of procedure: _____

Do you suffer from pain or discomfort in your ears? ☐ Yes ☐ No
Have you had chronic ear infections? ☐ Yes ☐ No
Do your ears produce a significant amount of wax? ☐ Yes ☐ No
Have you ever had any trauma to the head? ☐ Yes ☐ No
Are you experiencing any pressure in your ears? ☐ Yes ☐ No
Do you suffer from dizziness? ☐ Yes ☐ No
Do you suffer from tinnitus (ringing in the ears)? ☐ Yes ☐ No
Do you have a family history of hearing loss? ☐ Yes ☐ No
Are you currently using any medications? ☐ Yes ☐ No
If yes, please list: _____

Do you have a history of any of the following? ☐ Measles ☐ Mumps ☐ Diabetes ☐ Pneumonia
☐ Frequent Headaches ☐ High Fevers ☐ Meningitis ☐ Other (describe) _____
Have you been exposed to excessive noise levels without hearing protection in any of the following situations?
☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawn Mower
☐ Other (describe) _____
Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient vision ☐ Good ☐ Fair ☐ Poor

Have you ever utilized hearing aid(s)? ☐ Yes ☐ No If yes, describe your satisfaction: _____

_____

Which ears? ☐ Right ☐ Left ☐ Both ears

Make _____ Model _____

Who recommended the hearing aids(s)? _____

How many hours a day do you wear your hearing aid(s)? _____

Are there any specific features you are interested in for your hearing aid(s)? _____

_____

What are the top 3 environments you would like to hear better in?	SCALE OF 1-4	PRE	POST
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____