

# CONFIDENTIAL PATIENT INFORMATION

**Please complete the following information pertaining to your hearing:**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_ Date of Birth \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Present or previous occupation \_\_\_\_\_

Nearest relative's name and address \_\_\_\_\_

Marital Status:      Single      Widowed      Married      Name of Spouse \_\_\_\_\_

Email Address: \_\_\_\_\_

## MEDICAL HISTORY

Family Physician's Name and Address \_\_\_\_\_

Have you seen a doctor in the last six months?      Yes      No

If yes to the question above, have you seen a doctor specializing in diseases of the ear?      Yes      No

Please give doctor's name and date seen \_\_\_\_\_

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

When? \_\_\_\_\_ By whom? \_\_\_\_\_

What type of surgery? \_\_\_\_\_

Have you ever had your hearing tested?

When? \_\_\_\_\_ By whom? \_\_\_\_\_

What were the findings? \_\_\_\_\_

Is there a history of diabetes in your family?      Yes      No

Do we have your permission to send a copy of your test to your personal physician?      Yes      No

## ABOUT YOUR EARS

### **Do you have any of these symptoms?**

Deformity of the ear?	Yes	No	Hearing loss in one ear in the last 90 days?	Yes	No
Do you have any pain in your ears?	Yes	No	Have you ever seen a doctor for wax removal?	Yes	No
Sudden or rapid hearing loss in the past 90 days?	Yes	No	Drainage from either ear in the past 90 days?	Yes	No
Sudden or long-term dizziness?	Yes	No	Which is your poorer ear?		
				Left	Right      Same

## ABOUT YOUR HEARING

How long have you had a hearing problem? \_\_\_\_\_

### **Do you experience difficulty with...**

Understanding all the words in conversation clearly?      Yes      No

Hearing in a crowd or other noisy situations where background noise is present      Yes      No

Hearing by telephone?      Yes      No

### **Please answer the following questions about your hearing:**

Does anyone else in your family have a hearing problem?      Yes      No

What is their relationship to you? \_\_\_\_\_

Do you now or have you ever worn a hearing instrument?      Yes      No

What brand? \_\_\_\_\_

What were the results? \_\_\_\_\_

In what situations does your hearing problem give you the most trouble? \_\_\_\_\_

How did you hear about us?      Relative/Friend      Newspaper      Mail      TV      Doctor      Yellow Pages  
Other \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

124 E. Commercial  
Lebanon, MO 6536  
417-532-6856  
88-79-442



3797 Osage Beach Parkway  
Stone Crest Mal, F3  
Osage Beach, MO  
573-302-0340

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of "Notice of Privacy Practices" from Lake Area Hearing Solutions. I have read and understand the Notice of Privacy Practices and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

\_\_\_\_\_  
Signature of Client (or personal representative)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Printed Name of Personal Representative