DILES HEARING CENTER

Date: ________________________ **Referring Source** (if any): ______________________________________

Name: ____

Address: ____

City: _____________________________________ State: _________________ Zip Code: _______________

Phone: ___________________________________ Alternate/Cell Phone: _____________________________

Employer: ____

Address/City/State: ____

Soc. Sec. Number (optional): _______-_____-_______ Date of Birth: ______________ Gender: M ___ F ___

Marital Status: _______ Spouse/Partner's name __________________ Are you a student? ____________

Physician's Name: ____

Physician's Address/City/State: ____

May we send test results to your physician? YES _____ NO _____

Do you have hearing aid benefits? YES _____ NO _____ **If YES, please present insurance cards.**

E-mail address (please print): ____________________________________@ _________________________________

Have you visited our website: www.dileshearing.com? YES ______ NO ________

If YES, was it helpful? _______ Informative? ________ Easy to navigate? ___________

Any suggestions for improving it? ____

CLIENT HEALTH HISTORY

So we may better assist you, please answer the following questions to the best of your ability. The audiologist will review the responses with you.

Do you have a hearing loss? YES ☐ NO ☐ NOT SURE ☐ _______________

If YES, in which ear is the loss? RIGHT ☐ LEFT ☐ _____________________________

Have you ever had a hearing test? YES ☐ NO ☐ _____________________________

Have you **ever** worn a hearing aid? YES ☐ NO ☐ _____________________________

Do you wear a hearing aid **now**? YES ☐ NO ☐ _____________________________

Does anyone in your family have a hearing loss from birth? YES ☐ NO ☐ ________________

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Client Health History - *continued*

Have you ever been exposed to excessive noise through a job or hobby? YES ☐ NO ☐

Have you ever had chemotherapy? YES ☐ NO ☐ ____________________

Have you ever experienced dizziness? YES ☐ NO ☐ ____________________

Do you have tinnitus (ringing or buzzing)? YES ☐ NO ☐ ____________________

Have you ever had ear infections? YES ☐ NO ☐ ____________________

Which ear do you use for the telephone? RIGHT ☐ LEFT ☐

Please check any of the following that apply to you:

Pain in Ears	☐	Arthritis in Hands, Arms, and/or Shoulders	☐
Pressure in Ears	☐	Diabetes	☐
Drainage in Ears	☐	Taking Blood Thinners	☐
Odor from Ears	☐	Vertigo (not dizziness)	☐
Seen an Ear Specialist (ENT)	☐	Compromised Immune System	☐
Ear Surgery	☐	Taking Erectile Dysfunction (ED) Medications (such as Viagra, Levitra, or Cialis)	☐

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Please check the top 3 situations where you would like to hear better

☐ Television	☐ Restaurants	☐ Church
☐ Meetings/groups	☐ Telephone	☐ Spouse
☐ Children/Grandchildren	☐ Other: ____________________	