

**CALVERT HEARING CARE
PATIENT INFORMATION**

Patient Name _____

Date _____

HOW WERE YOU REFERRED TO OUR OFFICE – (be specific)

Referring Patient/Friend/Family Member _____

Referring Physician/Clinic _____

Yellow Pages _____ Newspaper _____

Promo/Mailer _____ Internet _____ Sign _____

MEDICAL HISTORY

Primary Care Physician: _____

Have you seen a physician regarding your hearing in the past six months? _____

Have you ever had ear surgery? _____ A sudden change in hearing? _____ Dizziness? _____

Are you diabetic? _____ Do you have thyroid trouble? _____ Do you have ear pain? _____

Do you have ear drainage? _____ Are you taking blood thinners (Coumadin/Aspirin)? _____

Do you feel your hearing is better in one ear than the other? _____

Do you have ringing or buzzing noises in your ears? _____

HEARING HISTORY

Is this your first hearing test? Yes _____ No _____

Have you noticed people seem to mumble? Yes _____ No _____

Do you often have to ask people to repeat themselves? Yes _____ No _____

Do you sometimes hear words, but not understand? Yes _____ No _____

Do you have problems understanding in noisy places? Yes _____ No _____

Have you been told that you speak too loudly? Yes _____ No _____

Is it hard to hear when you can't see the person speaking? Yes _____ No _____

Do you often miss the ringing of the telephone? Yes _____ No _____

Do you have difficulty hearing over the telephone? Yes _____ No _____

Do you avoid social situations because you can't hear? Yes _____ No _____

