Hearing Healthcare Center

3101 N. Green River Rd., Ste. 510
Evansville, IN 47715
812.303.4300

Date: 04 / 8 / 2021
PLEASE PRINT CLEARLY

Hello and welcome!

What is your hearing aid experience?

- ❑ I use hearing aids regularly
- ☑ I have hearing aids but rarely use them
- ☑ I have never used hearing aids
- ❑ I had my hearing tested at another office but never tried wearing hearing aids
- ❑ I once tried hearing aids but with no success

Name: _____ **Birth date:** _____/_____/_____

Sex: ❑Male ☑Female **Marital status:** ☑Single ❑Married (spouse: _____) ❑Widowed

Primary address: _____
Street City State ZIP

Home phone: (_____)_____ **Cell phone:** (_____)_____ **Work phone:** (_____)_____

E-mail address: _____

Primary physician: **Employer:**

_____ _____

Emergency contact: _____
Name Relationship Phone

1. Have you sought help for your hearing within the past 12 months? ☑Yes ☑No
2. From which ear do you hear better? ☑Right ☑Left ☑Both the same
3. Does your hearing change from time to time? ☑Yes ☑No
4. Have you been exposed to loud noises recently or in the past? ☑Yes ☑No
5. Are you dizzy at times or do you have balance problems? ☑Yes ☑No

Do you have:

1. Ear pain? ☑Right ☑Left
2. Ear drainage? ☑Right ☑Left
3. Fullness in the ears? ☑Right ☑Left
4. Ringing in the ears? ☑Right ☑Left

Please check all that apply:

☑High blood pressure ☑Heart attack ☑Pacemaker ☑Arthritis ☑Visual problems ☑Head injury ☑Aspirin therapy ☑Diabetes

❑Stroke ❑Other medical conditions:_____

❑Ear infections or surgery (include dates): _____