Welcome to Hanover Audiology

Please tell us a little about you….

PATIENT NAME: _____ Date of Birth: _____
ADDRESS: _____ Home Phone: (___)_____
CITY: _____ ST: _____ ZIP: _____ Cell Phone: (___)_____
E-MAIL ADDRESS: _____ *May we send you emails? (YES) or (NO)*
MARITAL STATUS: *Single* ___ *Married* ___ *Widowed*___ *Divorced*___ Social Security #: _____

EMPLOYER: _____ Work phone: (___)_____ _____
ADDRESS: _____ Occupation: _____
CITY: _____ ST: _____ ZIP: _____ *May we call you at work? (YES) or (NO)*

Alternate Contact (in case of Emergency)

NAME: _____ Relationship: _____
ADDRESS: _____ Home Phone: (___) _____
CITY: _____ ST: _____ ZIP: _____ Cell Phone: (___)_____

Family Physician: _____ Telephone: (___)_____
ADDRESS: _____ *May we send info to MD? (YES) or (NO)*

Insurance Information

Primary Insurance Carrier :_____ Telephone: (___)_____
Name of Policy Holder: _____ Relationship: _____
DOB (if not "self"): _____

Secondary Insurance Carrier :_____ Telephone: (___)_____
Name of Policy Holder: _____ Relationship: _____
DOB (if not "self"): _____

PURPOSE OF TODAY'S VISIT

_____
_____

Patient Audiologic History

YES	NO	
___	___	Any active drainage from either ear within the past three months?
___	___	Any history of sudden of rapidly progressive hearing loss within the past three months?
___	___	Have you experienced any recent (acute) or long term (chronic) dizziness?
___	___	Have you had your hearing tested before? If so, when was your last exam? _____
___	___	Which ear is your best ear? (Please circle) RIGHT LEFT BOTH THE SAME
___	___	Do you now or have you had chronic ear infections? If so, describe: _____
___	___	Have you received any medical or surgical treatment for hearing loss?
___	___	Have you seen a physician regarding your ears? If so, who? _____
___	___	Have you ever had a concussion, trauma or blow to your head? Describe: _____
___	___	Have you ever been exposed to loud or excessive noise? If so, occupational ____ or recreational ____?
___	___	Do you have ringing (tinnitus), noises or sounds in your ears or head? Describe: _____
___	___	Do you smoke or have you ever smoked? If so, how much per day? _____
___	___	Have you ever worn a hearing aid before? If so, when and describe your experience(s) with your hearing aid(s): _____
		_____

Family History

Please indicate in the box below any listed family member(s) who have had any of the following:

Health Condition	SELF	Parents	Siblings	Other Relatives
Allergies				
Arthritis				
Cancer-site & type				
Diabetes				
Emphysema/COPD				
Hearing Loss				
Heart Attack				
HBP/Hypertension				
Mumps/Measles/Rubella				
Pacemaker				
Parkinson's/Tremors				
Sickle Cell or Trait				
Sleep Apnea				
Stroke/TIA				
Thyroid Problem				
Other:				

Medications and Allergy History

MEDICATIONS

Please list ALL medications (and dosage), including non-prescription supplements and over-the-counter.

◯ **I DO NOT USE any medications regularly**

ALLERGIES

Please list ALL allergies to medication(s), or non-drug related items (environmental, food, insects, inhalants).

◯ **I HAVE NO allergies**

_____ _____

SIGNATURE of PATIENT/Representative of PATIENT DATE