delaney hearing center

PERSONAL INFORMATION:

Name:_____ DOB:_____ Date:_____

Gender: ☐ Male ☐ Female ☐ Non-Binary Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Guardian / POA: _____ (If POA, please bring a copy for our records)

Address: _____

City: _____ State: _____ Zip: _____ Home phone: _____

Cell phone: _____ Work phone: _____ Other: _____

Email address: _____ SSN: _____

Current Employment: ☐ Full-Time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Student

Current Employer / Occupation (if retired list prior occupation): _____

Emergency Contact: _____ Phone: _____

Relationship: _____ City/State:_____

REFERRAL INFORMATION:

Who referred you or how did you find out about us? _____

Primary Care Physician: _____ Phone: _____

If your primary care physician DID NOT refer you to us, do we have permission to send them your results?

☐ YES ☐ NO

INSURANCE INFORMATION:

Please fill out the information below and provide the front desk with your insurance cards for copying to assist us in billing your insurance company for you.

Primary Insurance: _____ Secondary Insurance: _____

Member ID: _____ Member ID:_____

Insured's Name:_____ Insured's Name: _____

Insured's DOB: _____ Insured's DOB: _____

Insured's relationship to patient:_____ Insured's relationship to patient:_____

Insured's Employer: _____ Insured's Employer: _____

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HEARING HISTORY:

Reason for today's appointment: _____

Do you notice difficulty hearing? ☐ YES ☐ NO If so, which ear? ☐ Right ☐ Left ☐ Both

If you experience hearing loss, which best describes it? ☐ Gradual ☐ Sudden ☐ Changes ☐ Stays the same

When was it first noticed? _____ By whom? _____

Can you relate any change in your hearing to any of the following?

☐ Ear infection / draining ears ☐ Accident / fall:_____ ☐ Stress / Life change
☐ Medical Condition: _____ ☐ Illness / Hospitalization: _____
☐ Change in Medication: _____ ☐ Other: _____

Can you hear sounds but not understand the words clearly? ☐ YES ☐ NO

Please check any of the following situations where you have difficulty communicating / understanding?

☐ Noisy places ☐ Quiet places ☐ Television ☐ Work ☐ Meetings / Lectures ☐ Phone
☐ Restaurants ☐ Religious Services ☐ Family Gatherings ☐ Other: _____

Do people complain that you play the radio or television too loud? ☐ YES ☐ NO

Have you had a hearing test before? ☐ YES ☐ NO If yes, when and where? _____

Have you had ear infections or drainage in the past 90 days? ☐ YES ☐ NO

Have you had any medical/surgical treatment for your ears? ☐ YES ☐ NO
If yes, please describe: _____

Do any of your family members have hearing loss or other ear-related issues? ☐ YES ☐ NO
If so, who? ☐ Mother ☐ Father ☐ Sister ☐ Brother ☐ Aunt ☐ Uncle ☐ Grandparent(s) ☐ Cousin

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Do you have any ringing, buzzing, noises (tinnitus) in your ears or head? ☐ YES ☐ NO
If yes, how long have you had tinnitus? _____
If yes, where? ☐ Right Ear ☐ Left Ear ☐ Both Ears ☐ In your head
If yes, is it: ☐ Constant ☐ Periodic – how often?: _____
If yes, please describe it: ☐ Ringing ☐ Buzzing ☐ Static ☐ Hissing ☐ Chirping ☐ Pulsating
☐ Humming ☐ Tone ☐ Air Conditioner ☐ Other: _____

Have you ever been exposed to any of the following noises at ANY time in your life? (check all that apply)

☐ Gunfire ☐ Farm Equipment ☐ Military-related noise ☐ Loud Machinery ☐ Loud Music
☐ Firecrackers ☐ Explosions ☐ Power Tools ☐ Motorcycles ☐ Other loud noises: _____

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HEARING HISTORY (continued):

Which ear do you use on the phone? ☐ Right ☐ Left ☐ Neither, I use speakerphone

Do you use a landline? ☐ YES ☐ NO Do you use a cell phone? ☐ YES ☐ NO

Is your cell phone an iPhone (Apple)? ☐ YES ☐ NO Which do you use the most? ☐ Cell ☐ Home

FALLS RISK ASSESSMENT:

Have you ever experienced dizziness, unsteadiness, imbalance or vertigo? ☐ YES ☐ NO

If yes, is your Primary Care Physician aware of this? ☐ YES ☐ NO

If yes, what kind of treatment did or are you receiving? _____

If yes, how often do you have an episode? _____

If yes, when was the last time you had an episode? _____

If yes, is it accompanied by (check all that apply):

☐ Nausea ☐ Visual disturbances ☐ Ringing/noises in your ears ☐ Hearing loss

If yes, are you feeling dizzy today? ☐ YES ☐ NO

If yes, please describe: _____

Have you fallen in the last 12 months? ☐ YES ☐ NO If yes, how many times? _____

If you have fallen, have you been injured? ☐ YES ☐ NO

If yes, please describe your injury: _____

Do you experience visual disturbance? ☐ YES ☐ NO If yes, pleas describe:_____

Do you take a vitamin D supplement? ☐ YES ☐ NO

Have you seen any of the following specialists for dizziness or imbalance?

☐ ENT / Otologist ☐ Physical Therapist ☐ Neurologist ☐ Other:_____

MEDICAL HISTORY:

Have you been seen by an ear doctor (ENT)? ☐ YES ☐ NO If yes, who? _____

Have you been seen by a Neurologist? ☐ YES ☐ NO If yes, who? _____

Have you been seen by a Psychiatrist? ☐ YES ☐ NO If yes, who? _____

When was your last eye exam? _____ Do you have macular degeneration? ☐ YES ☐ NO

Do you wear glasses? ☐ YES ☐ NO Do you have cataracts? ☐ YES ☐ NO

Is your corrected vision: ☐ Good ☐ Fair ☐ Poor

Have you used tobacco products (cigarettes, cigar, smokeless tobacco) one or more times in the past 24 months? ☐ YES ☐ NO If yes, how often and what type? _____

MEDICAL HISTORY (continued):

Please check the boxes if you currently have or have had in the past any of the following medical conditions:

- ☐ Arthritis
- ☐ Allergies
- ☐ Anxiety
- ☐ Bell's Palsy
- ☐ Cancer
- ☐ COVID-19
- ☐ Depression
- ☐ Dementia/Alzheimer's
- ☐ Diabetes
- ☐ Headaches/Migraines
- ☐ Head Trauma
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Fevers / Mumps
- ☐ HIV /AIDS
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Kidney/Renal Disease
- ☐ Meniere's Disease
- ☐ Meningitis
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Neurofibromatosis
- ☐ Pacemaker
- ☐ Parkinson's
- ☐ Seizures
- ☐ Stroke / TIA
- ☐ Vascular Problems
- ☐ Serious Infection / Hospitalization :_____
- ☐ Heart attack / Heart disease: _____
- ☐ Autoimmune disease: _____
- ☐ Other, not listed: _____

MEDICATIONS:

Please list ALL medications you are taking, including prescriptions, over-the-counter, herbals, and vitamin/mineral/dietary supplements. IF YOU HAVE A LIST THAT WE CAN COPY please give it to the front desk when you arrive (and you may skip this section).

Medication Name	Dosage	Frequency	Delivery Method (oral, injection)

HEARING AID HISTORY:

- **If you have NEVER worn hearing aids, please skip this page.**
- **If you CURRENTLY wear hearing aids, please answer the below questions:**

On which ear do you wear the hearing aid(s): ☐ Right ☐ Left ☐ Both

Are you satisfied with your hearing aid(s): ☐ YES ☐ NO Comments: _____

How old is/are your hearing aid(s)? _____ When did you get your first hearing aid(s)?_____

How often do you wear the hearing aid(s)? ☐ Every day ☐ Only when I go out ☐ Just in the evening

How many hours a day do you wear your hearing aid(s)? _____

Where did you get your hearing aids? _____

If you know the brand of hearing aid(s) you use, please check below:

☐ Phonak ☐ Unitron ☐ Widex ☐ Siemens ☐ Starkey ☐ Resound ☐ Oticon ☐ Signia

Indicate any problems you have with your hearing aid(s): *(check all that apply)*

☐ Putting it on ☐ Taking it off ☐ Painful / Uncomfortable ☐ Feedback / whistling

☐ Too loud ☐ Too soft ☐ Unpleasant sounding ☐ Words are not clear

☐ Falls off ☐ Too visible ☐ Not helpful in quiet ☐ Batteries too hard to change

☐ Not helpful in noise ☐ Not helpful on the telephone ☐ Difficulty with volume control

Other (please describe): _____

- **If you PREVIOUSLY wore hearing aids, but do not wear them now, please answer the below questions:**

How long did you wear the hearing aid(s)? _____

How long ago did you stop wearing the hearing aid(s)? _____

Why did you stop using your hearing aid(s)? *(check all that apply)*

☐ Too difficult to put on and off ☐ Painful / Uncomfortable ☐ Unpleasant sounding ☐ Too loud

☐ Too soft ☐ Too much feedback / whistling ☐ Difficulty with volume control ☐ It is broken

☐ Not helpful in noise ☐ Did not feel it was helping ☐ It kept falling off ☐ Did not feel I needed it

☐ I lost it ☐ Other (please describe): _____

STAFF NOTES:

_____

_____

_____