PATIENT HISTORY & INTAKE FORM

Marin Hearing Center
45 San Clemente Drive, Suite D140
Corte Madera, CA 94925
Phone: 415-927-1567
FAX: 415-329-1924

Patient: _____ Birthdate: _____ Date: _____
(please print)

1. Reason for today's visit:

2. Referred by:

3. Primary care physician:

4. Primary care physician phone number & address:

5. Have you had any of the following conditions? If YES, briefly explain.
   - ☐ Kidney Disease
   - ☐ Diabetes
   - ☐ Cancer
   - ☐ Hypertension
   - ☐ Visual Problems
   - ☐ Sinus Problems

   Additional Comments:

6. List all medications you are currently taking, including herbal, supplements, non-prescription. Please include dose and frequency taken:

Medication name:	Dose:	How often taken:	Route (oral, shots, dermal, etc.)

7. Have you ever experienced head trauma? If YES, briefly explain.
   - ☐ Yes

☐ No

Additional Comments:

8. Have you ever had surgery on your ear(s) nose, or throat? If YES, briefly explain.
   ☐ Yes
   ☐ No

   Additional Comments:

9. When did you first notice your hearing problem?

10. Was your change in hearing SUDDEN or GRADUAL?
    ☐ Sudden
    ☐ Gradual

11. Has your hearing become worse since you first noticed the problem?
    ☐ Yes
    ☐ No

12. Do you hear better in one ear than the other?
    ☐ Yes, right ear is better
    ☐ Yes, left ear is better
    ☐ No

13. Does your hearing REMAIN CONSTANT or FLUCTUATE?
    ☐ Remains Constant
    ☐ Fluctuates

14. Have you experienced any recent or current ear pain?
    ☐ Yes, both ears
    ☐ Yes, left ear only
    ☐ Yes, right ear only
    ☐ No

15. Do your ears feel plugged?
    ☐ Yes, both ears
    ☐ Yes, left ear only
    ☐ Yes, right ear only
    ☐ No

16. Are you experienced any ringing, buzzing, or other noises in your ears?
- ☐ Yes, both ears or "in head"
- ☐ Yes, left ear only
- ☐ Yes, right ear only
- ☐ No

Additional Comments:

17. Have you experienced any dizziness/vertigo? If YES, briefly explain and note if current or past.
- ☐ Yes
- ☐ No

Additional Comments:

18. Have you ever been exposed to loud noise (work, recreation, military service)? If YES, briefly explain.
- ☐ Yes
- ☐ No

Additional Comments:

19. Do you use tobacco?
- ☐ Yes
- ☐ No

20. Has anyone in your family experienced hearing loss? If YES, who and at what age?
- ☐ Yes
- ☐ No

Additional Comments:

21. In which situations do you have difficulty hearing?

22. Have you had your hearing tested before? If YES, briefly explain (where/when).
- ☐ Yes
- ☐ No

Additional Comments:

23. Have you ever worn hearing instruments? If YES, briefly explain.
- ☐ Yes, currently
- ☐ Yes, in the past
- ☐ No

Additional Comments:

24. Please provide your mailing address:

25. Home Phone #:

26. Work Phone #:

27. Cell Phone #:

28. Email:

29. Employment:
- ☐ Employed
- ☐ Full-time student
- ☐ Part-time student
- ☐ Other

30. Marital Status:
- ☐ Single
- ☐ Married
- ☐ Other

30. Signature: