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## PATIENT HISTORY & INTAKE FORM

| Patient (please print): |  |                                   |  |  |
|-------------------------|--|-----------------------------------|--|--|
| Bii                     | rthdate:   | Date:                             |  |  |
| 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 cond<br>Kidney Disease<br>Diabetes | ditions? If YES, briefly explain. |  |  |
|                         | 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) |  |  |  |
|   |           |                        |                              |  |  |  |
|   |           |                        |                              |  |  |  |
| 7. Have you ever experienced Yes No   | nead trai | uma? If YES, briefly   | explain.                     |  |  |  |
| Additional Comments:  |           |                        |                              |  |  |  |
| 8. Have you ever had surgery of Yes  No   | on your e | ear(s) nose, or throat | ? If YES, briefly explain.   |  |  |  |
| Additional Comments:  |           |                        |                              |  |  |  |
| 9. When did you first notice you  | ur hearin | g problem?             |                              |  |  |  |
| 10. Was your change in hearing<br>Sudden<br>Gradual                                   | g SUDDE   | N or 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:  |

| 1 2 3 4 5 6 7 8 9 10  |    |
|---|----|
| rate your overall hearing ability?  |    |
| 22. On a scale from 1 to 10, 1 being the worst and 10 being the best, how would you   |    |
| 21. In which situations do you have difficulty hearing?   |    |
| 20. Has anyone in your family experienced hearing loss? If YES, who and at what age Yes  No  Additional Comments:                           | e? |
| 19. Do you use tobacco? Yes No  |    |
| 18. Have you ever been exposed to loud noise (work, recreation, military service)?  If YES, briefly explain.  Yes  No  Additional Comments: |    |
| current or past.  Yes  No  Additional Comments:   |    |
|   |    |

17. Have you experienced any dizziness/vertigo? If YES, briefly explain and note if

| 23. Have you had your hearing tested before? If YES, briefly explain (where/when).  Yes  No                                      |
|--|
| Additional Comments:   |
| 24. Have you ever worn hearing instruments? If YES, briefly explain.  Yes, currently  Yes, in the past  No  Additional Comments: |
| 25. Please provide your mailing address:   |
| 26. Home Phone #:  |
| 27. Work Phone #:  |
| 28. Cell Phone #:  |
| 29. Email:   |
| 30. Employment: Employed Retired Other:  |

31. Marital Status:

Single

Married

Other

32. Signature: