

PATIENT MEDICAL INTAKE FORM

Name _____ DOB ____/____/____ Date _____

When was your last hearing exam? _____ By whom? _____

What were the recommendations? _____

Do you currently wear hearing aids? ☐ Yes ☐ No

If yes, for how long? _____

When did you first notice a decline in your hearing? _____

☐ Within the last 90 days ☐ 1–3 years ago ☐ 4–6 years ago ☐ 7–10 years ago ☐ 10+ years ago

Do you have any history of the following?

☐ Family history of hearing loss

☐ Diabetes

☐ High blood pressure

☐ Chemotherapy

☐ Decrease in memory

☐ Depression or anxiety

☐ Noise exposure

☐ High cholesterol

☐ Radiation

☐ Cardiovascular disease

☐ Arthritis

Do you experience fullness or pressure sensation in your ears? ☐ Yes ☐ No

Do you have pain in your ears? ☐ Yes ☐ No

Do you have ringing in your ears? ☐ Yes ☐ No

☐ Constant ☐ Occasional Sounds like _____

Do you have difficulty understanding others during conversations? ☐ Yes ☐ No

Do you have any vertigo/dizziness/unsteadiness? ☐ Yes ☐ No

If a hearing aid is recommended for you, please rank the following in order of importance (1–4):

____ Improved hearing in quiet ____ Improved hearing in noise/group situations

____ Cosmetic appearance ____ Expense

Please list any prescription medications that you take on a regular basis:

Medication	Taken For