CONFIDENTIAL HEARING HEALTH QUESTIONNAIRE
For the patients of Focus Hearing

Client History

PLEASE PRINT

Last Name ____________________ First Name __________________ MI ___ Date of Birth _________

Address ____ City _________________________

State ______________ Zip _______________ ☐ Male ☐ Female

Phone (______) __________ - __________ E-Mail address ____

Past/Present Occupation ________________________________ Retired ☐ Yes ☐ No

Preferred Contact Name and Phone # (if other than self) ____

Accompanying Party ____ Relationship ________________

Family Physician Name ___________________________City ____________________ State ____________

Insurance Carrier ______________ Primary Insured ___________________Primary DOB __________

Referral Source: ☐ Doctor ☐ Family/Friend ☐ Website ☐ Direct Mail ☐ Other ______________

Medical and Hearing Health History

Do you have any allergies? ☐ Yes ☐ No If yes, please list____________________

Are you a diabetic? ☐ Yes ☐ No If yes, are you insulin dependent? ____

Do you have arthritis/rheumatoid arthritis? ☐ Yes ☐ No

Are you currently taking any medications? ☐ Yes ☐ No If yes, please list on back of this form

Are you taking any blood thinners? (aspirin) ☐ Yes ☐ No If yes, please list ____________________

Amplification History

Are you a current hearing aid wearer? ☐ Yes ☐ No If yes, since when? ________________________

Type ________________________________ Ear Fitted: ☐ Both ☐ Left ☐ Right

If yes, what would you improve about your current hearing aid? ________________________________

Do you have ringing or other noises in your ears? ☐ Yes ☐ No If yes, which ear? _____________

Have you previously had a hearing test? ☐ Yes ☐ No If yes, by whom/when? ________

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Have you received any medical or surgical treatment for hearing loss? ☐ Yes ☐ No

If yes, when? _________________________ Details ____

Physician/ENT ____________________________ City ___________________ Phone _________________

Any other information about your hearing that you would like to share with us?

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____ ______/______/______

Patient Signature Date