P. Chris Lawrence, BC-HIS

Patient Information

Patient Name _________________________________ Age ______ Date of Birth _________

Martial Status (S M W D) Occupation (Current or previous)___________________________________

Spouse Name___________________________ Phone Home _______________ Cell_________________

Street Address ________________________ City ________________ State ___________Zip_________

E-Mail address____________________________ **How did you hear about our clinic?** _______________

Confidential Patient Case History (Please circle your answer)

Have you seen a doctor in the last 6 months? ___________________ Yes No

When was your last Hearing Test? ____________________________ _______

Have you had any surgery on your ears? _______________________ Yes No

Do you have any pain in your ears?___________________________ Yes No

Do you have ringing in your ears?___________________________ Yes No

Do you have drainage in your ears?____________________________ Yes No

Have you experienced sudden or rapid hearing loss? ___________ Yes No

Which ear is worse? _______________________________________ R L Same

Have you ever taken medication that is known to be harmful
to your hearing?____ Yes No

Are you currently taking blood thinners? _______________________ Yes No

Hearing History

Do you feel like people are mumbling as they speak?_____________ Yes No

Do you frequently ask people to repeat themselves? _____________ Yes No

Do you have trouble hearing in noisy situations? _______________ Yes No

Have others told you that you speak too loudly? _______________ Yes No

Do others complain your TV is too loud? _______________________ Yes No

Do you have difficulty listening on the phone? __________________ Yes No

Do you avoid social events because of hearing difficultly? ________ Yes No

How many years have you experience hearing difficulty?_________

Hearing Aid Info

Do you currently wear hearing aids? Yes No

If so what brand name and type? Brand____________ Type____________ Year Purchased_______

If not, will you wear a Hearing Aid if it can help you hear better and increase the quality of your life?

YES NO Comments ____

I understand the hearing Screening is complimentary but should I request a copy of the results, I will be charged at the discretion of the provider.

Patient Signature _________________________________Date______________________