SONOLOGY
HEARING AID CLINIC

Please Print

Date:_____

Last Name_____ First Name_____ MI_____

Address_____ □ Male □Female □Married □Single □Widow(er)

City_____ State_____ Zip_____

Phone ( )_____-_____

E-Mail Address_____

Date of Birth_____-_____-_____

Occupation_____

Primary Physician: Name_____City_____ Phone_____

Permission to add you to our email list? ◻Yes ◻ No

Patient Signature_____

MEDICAL AND HEARING HEALTH PROFILE

In which ear have you noticed difficulty hearing?	◻Right	◻Left	◻Both
Do you have any of the following:	□Yes	□No	
Pain or discomfort in the ear?	◻Yes	◻No	
Ringing or noises in the ear?	◻Yes	◻No	
Recent dizziness or balance issues?	◻Yes	◻No	
Active drainage from the ear?	◻Yes	◻No	
Sudden hearing loss in the past 90 days?	◻Yes	◻No	
Family history of hearing loss?	◻Yes	◻No	
Exposure to excessive noise?	◻Yes	◻No	
Have you received any medical/ surgical treatment for your hearing loss?	◻Yes	◻No	

If Yes, When?_____

Physician/ENT_____City_____

Phone_____

AMPLIFICATION HISTORY

Are you a current hearing aid wearer? ◻Yes ◻ No

If so, what type of hearing aid(s) are you wearing? _____

Do you use your hearing aid(s) several hours each day? ◻ Yes ◻ No

If yes, what would you want to improve about your current aid(s)?_____

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