Patient Information

Thank you so much for choosing Oconee Audiology for your hearing healthcare. We appreciate your business and look forward to working with you. Please complete the following two pages so that we may better serve you.

Name:_____ Date of Birth: _____

Mailing Address: Street _____ City_____State_____ Zip_____

Telephone Number: _____ Email: _____

Insurance Carrier: _____

Primary Care Doctor: _____Where is your doctor located? _____

May we send your doctor a report regarding your visit today? ___ Yes ___ No

How did you hear about us? _____

HEARING HISTORY

Will this be the first time you've had a hearing test? ___ Yes ___ No

If no, when were you last tested? _____

Do you or have you had chronic ear infections? ___ Yes ___ No

Do you have a family history of hearing loss? ___ Yes ___ No

Do you have a history of noise exposure? ___ Yes ___ No

Do you have difficulty hearing when someone speaks softly? ___ Yes ___ No

Does a hearing issue cause you difficulty when visiting friends or family? ___ Yes ___ No

Does a hearing issue cause you to withdraw from social situations? ___ Yes ___ No

Does a hearing issue cause difficulty watching/enjoying TV or movies? ___ Yes ___ No

Does a hearing issue cause difficulty hearing women or children's voices? ___ Yes ___ No

Do you hear better in one ear? If yes, which ear is better? ___ R ___ L ___ Yes ___ No

Do you consider your life to be: _____ active and busy/very social _____ Quiet/Mostly home

Do you frequently go to restaurants or attend group functions? ___ Yes ___ No

Do you currently wear hearing aids? ___ Yes ___ No

If yes, what would you change about them if you could? _____

Why have you decided to visit with us today?

____ I feel my hearing is poor and may need to be aided

____ Family/friends have suggested I have my hearing checked

____ Other: _____

MEDICAL HISTORY:

Please check mark next to the symptoms if you have had, or currently have any of the following:

____ High blood pressure	____ Heart disease	____ Ear Surgery
____ Arthritis	____ Diabetes	____ Ear Pain
____ Cancer	____ Ringing in the ears	____ Recurring dizziness
____ Stroke	____ Sudden decrease in hearing	____ Ear infection

Medicines you are currently taking: _____

_____

_____

PRIORITIES ASSESSMENT

The following is a list of important factors to consider when determining which type of hearing instrument is appropriate for you. Please rate them in order of importance from 1 to 6 by placing the number "1" next to the most important factor, the number "2" next to the second most important factor, and so on through to number "6" being the least important factor to you.

____ Understanding speech better	____ Function in a noisy environment
____ Appearance	____ Cost
____ Comfort	____ Service

AUTHORIZATION

I agree to allow Oconee Audiology to send me offers and/or promotions via mail and/or email to keep me updated on the latest and most advanced hearing technologies available, as well as any upcoming scheduled marketing events.

_____ _____

Signature Date