Kos/Danchak
AUDIOLOGY & HEARING AIDS

ADULT PATIENT INFORMATION

Birth Date: _____ Gender: _____ Social Security Number: _____

Name: _____
First Middle Last

Mailing Address: _____
Street City State Zip

Occupation: _____ Employer: _____

Phone Number: Home ( )_____ Work: ( )_____ E-mail: _____

Can you be reached or receive messages at work? _____ During what hours? _____

Spouse's Name: Birth Date: _____ S.S. #: _____

Spouse's Occupation: _____ Employer: _____

Spouse's Business Phone Number: ( )_____ When can he (she) be reached? _____

Who referred you to this office? _____ Who will be responsible for payment? _____

Primary Health Insurance: _____ Secondary Health Insurance: _____

Family Doctor: _____ Telephone: _____ Need a report to your doctor? ☐ Yes ☐ No

MEDICAL HISTORY

Place a check next to any of the following that you have had or currently have:

☐ Diabetes	☐ Heart Disease	☐ Stroke
☐ High Blood Pressure	☐ Arthritis	☐ Kidney Disease
☐ Cancer	☐ Mumps	☐ Measles
☐ Meningitis	☐ Head Trauma	☐ Sleep Issues
☐ Neurologic Impairment/Headaches	☐ Anxiety/Depression	☐ Change in Appetite
☐ Lack of Energy	☐ Suicidal Thoughts or Attempts	☐ IV Antibiotics
☐ Alcohol Use	☐ Tobacco Use	☐ Other: _____

Please list any medications that you take, including prescription, over-the-counter, herbals, vitamin/mineral/dietary supplements taken routinely or on an as-needed basis.

Name: Dosage: Frequency taken: Route of administration (ex. oral):

_____

_____

_____

_____

Why have you decided to have your hearing tested at this time?

- ☐ I feel my hearing is poor and may need to be aided.
- ☐ Family/friends have suggested I have my hearing checked.
- ☐ My tinnitus is really bothering me.
- ☐ My sensitivity to sound is really bothering me.
- ☐ Other reason: _____