
Cy-Fair Hearing Aids Case History Form

**PERSONAL INFORMATION**

Patient Name: _____Appointment Date:_____

Date of Birth: _____ Age: _____ Gender: Male Female

Marital Status: Single Married Divorced Widowed Spouse Name:_____

Primary Language: _____

Address:_____City_____Zip Code_____

Home Phone #:_____ Cell Phone #:_____

Email:_____

Current Employment: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer (if retired list prior occupation): _____

Position: _____ Family Physician: _____

Have you or your spouse ever been in the military? Yes_____ No_____ # of Years_____

Referral information: How did you hear about us?

Patient/Friend:_____ Mail Internet Manufacturer Third Party/Insurance Doctor

Reason for the appointment: _____

**INSURANCE INFORMATION-** Please give your insurance cards to out Patient Care Coordinator so we can make a copy for our records.

Primary Insurance:_____Member ID:_____

Insured's Name:_____DOB_____ Relationship to Insured:_____

Secondary Insurance:_____ Member ID: _____

Insured's Name:_____ Relationship to Insured:_____

**FOR HEARING AID WEARERS, PLEASE ANSWER THE FOLLOWING:**

**Do you experience any of the following with your current hearing aid(s). Please circle all that apply:**

| | | |
|---|---|---|
| Some sounds are too loud | Trouble understanding in quiet | Trouble understanding in noise |
| Sounds are too soft | Wind Noise | Don't like the appearance of aid |
| Pain:_____ | Trouble with the phone | Don't like the sound of own voice |
| Sounds are tinny | Feedback or whistling | Can't tell direction of sound |
| Trouble cleaning aids | Trouble changing battery | Short battery life: _____ |
| Naturalness of sound | Repair issues | Other:_____ |

## AUDIOLOGIC HISTORY

**Do you feel you have a hearing loss?** Yes No Which ear? Right Left Both

**If you answered yes, which best describes it?** Gradual Fluctuating Sudden

**When did you first notice your hearing loss?** _____

**What do you think is the cause of your hearing loss?**_____

**Have you ever had a hearing evaluation?** Yes No When/Where?_____

**Which ear do you use to talk on the phone**: Right Left

**Do you use a home or cell phone primarily?**_____

**iPhone or Android?**_____

**Have you ever worn or tried a hearing aid?** Right ear Left ear Both ears

**What type and/or style of hearing aid**:_____

**Please describe your experience**:_____

_____

_____

**PLEASE CHECK ALL MEDICAL CONDITIONS THAT APPLY:**

____Developmental Disorders/Delay Please explain:_____

____Dizziness/Vertigo/Unsteadiness If checked: vomiting nausea

____Ear Deformity If checked: Right Ear Left Ear Both Ears

____Ear Drainage If checked: Right Ear Left Ear Both Ears

____Ear Pain If checked: Right Ear Left Ear Both Ears

____Family history of hearing loss Who in the family:_____

____History of Ear Infections If checked: Right Ear Left Ear Both Ears

____History of ear wax buildup If checked: Right Ear Left Ear Both Ears

____History of Noise Exposure Please explain:_____

____Previous Ear Surgery If checked: Right Ear Left Ear When?_____

____Tinnitus/Ringing or Noise in Ears If checked: Right Ear Left Ear Frequency?_____

____Fullness in the Ear If checked: Right Ear Left Ear Started?_____

____Other: Please explain:_____

**MEDICAL HISTORY**

Any other illness, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence:_____

_____

_____

Allergies (food, medication, plastics, latex):_____

**Have you experienced any of the following major medical conditions?**

___AIDS/HIV ___Diphtheria ___High Blood Pressure ___Mumps ____Appetite Change

___Encephalitis ___High Fevers ___Scarlet Fever ____Arthritis ___Fatigue ___Influenza

___Stroke ___Blood Disorders ____Genetic Disorders ___Malaise ___Tonsillitis ___Cancer

___Headaches ___Malaria ____Typhoid ____Chicken Pox ____Head Injury ___Heart Problems

___Meningitis ___Other:_____

**List All Current Medications (over counter, prescriptions, or recreational):**

_____

_____

_____

**Do you currently use tobacco?** Yes No

**PLEASE CHECK ALL MEDICAL SYMPTOMS THAT APPLY:**

___Eye Problems (such as blurred vision, pain)

___Nose, Throat, or Mouth problems (such as trouble swallowing, nose bleeds, dental issues, pain)

___Cardiovascular Symptoms (hypertension, chest pain, swelling, palpitations)

___Respiratory Symptoms (shortness of breath, cough, wheezing)

___Gastrointestinal Issues (nausea, vomiting, weight changes, diarrhea, pain)

___Musculoskeletal Symptoms (joint pain, swelling, recent trauma)

___Neurologic Symptoms (numbness, headaches, seizures, muscle weakness)

___Psychiatric Issues (depression, anxiety, compulsions)

___Endocrine Symptoms (frequent urination, hot flashes)

___Hematologic/Lymphatic Symptoms (bleeding gums, bruising, swollen glands)

___Allergic/Immunologic Symptoms (hives, asthma, itching, immune deficiency)

Additional
Comments:_____

_____

_____

**POLICY**

_____We ask that all office visits and services be paid at the time they are provided. Although we will gladly check your insurance benefits, at this time we are not able to bill your insurance for services and products. All payments are the responsibility of the patient.

**PERMISSION TO EVALUATE**

_____I authorize you to assess my auditory system and rehabilitative needs. These may include comprehensive audiometry threshold evaluation, speech recognition, tympanometry, acoustic reflex testing and earmold impressions.

**AUTHORIZATION TO RELEASE MEDICAL RECORDS**

_____We provide you with important diagnostic information about your hearing. We feel it is important for your physician to have this information for your medical records. By signing this form you are providing us permission to send a copy to your physician. This release will be in effect until we receive written notice that you no longer want us to forward this information.

**AUTHORIZATION OF OBTAIN MEDICAL RECORDS**

_____In order to provide you with the best service possible, we may be required to contact your previous audiologist, hearing aid dispenser, or hearing aid manufacturer for information regarding your hearing, hearing aid information, warranty, etc. We will not be requesting medical information from a physician without a separate consent. This release will be in effect until we receive written notice that you no longer want us to forward this information

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT OF RECEIPT**

_____I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Cy-Fair Hearing Aids, a copy of which is available at the front desk. I understand that a copy of this notice will be made available to me at my request.

_____ I Authorize marketing communication from this practice means I may:
Receive treatment communications concerning treatment alternatives or other hearing related products or services. Be contacted for appointment reminders or information about treatment alternatives or other hearing benefits and services that may interest me. To receive Marketing Communications from this Practice Only
*I understand that I have the right to “opt out” of receiving such communications.

_____ _____ _____

Signature of Patient | Signature of Parent or Guardian | Date

If patient is a minor/ relationship to the minor

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