Ohio Head & Neck Surgeons
Audiology Department

Patient Name:____ M or F

Address:_____________________________City:_____________State_____Zip____________

Phone Number:_________________________ Birthdate:______________________________

Referring Physician:______________________Family Physician:__________________________

Primary Insurance Co.____

Secondary Insurance Co.____

Have you been examined by a physician in the last 6 months? Yes No

Do you have any of the following?

Ear surgery	Yes	No
Deformity of the ear	Yes	No
Sudden or rapid hearing loss	Yes	No
Pain or discomfort in the ear	Yes	No
Acute or recurring dizziness	Yes	No
Ringing in the ears	Yes	No
Previous ear infections	Yes	No
Active drainage from the ear	Yes	No
Had wax removed from your ears by a doctor	Yes	No
Does one ear hear better	Right	Left
History of noise exposure	Yes	No
Do you have any medical problems	Yes	No

Please list:____

Are you taking any medications?

List:____

Do you have a hearing aid(s)? Yes No

Do you wear the aids in both ears or right or left?

How often do you wear your hearing aids? Rarely Part-time Full-time Special Occasions

How old are your hearing aids? ________________

I have been advised by the Audiology Department at Ohio Head and Neck Surgeons that the Food and Drug Administration has determined my best interests would be served if I had a medical evaluation by a licensed physician (preferably by a physician that specializes in diseases of the ears) before purchasing a hearing instrument. I do not wish a medical evaluation before purchasing an instrument. This test information shall be compiled for the purpose of making selections and adaptations of hearing instrumentation. I attest that I am at least 18 years old.

Signature:____________________________________Date:_________________________