Dr. Mimi's Audiology Clinic

"Our Services Put a Smile on Your Face"

Patient Name:_____ Spouse:_____

Address:_____

City:_____ State:_____ Zip:_____

Phone:_____ Cell:_____

Birth Date:_____ Email:_____

Occupation:_____ Retired? YES NO

Family Physician:_____ Phone Number:_____ City:_____

ENT Physician:_____ Phone Number:_____ City:_____

Referred By:_____ Emergency Contact Name & Phone:_____

Medical History

(Please Circle One)

Will this be your first hearing test?	YES	NO	
Have you been examined by a doctor in the past six months?	YES	NO	
Have you ever had ear surgery?	YES	NO	
Have you ever experienced any of the following:			
Deformity of the ear?	YES	NO	
Ear drainage?	YES	NO	
Sudden and rapid hearing loss?	YES	NO	
Acute of reoccurring dizziness?	YES	NO	
Do you have any ringing (Tinnitus) in your ears?	YES	NO	
Have a doctor remove wax from your ears?	YES	NO	
Are you experiencing ear pain, now?	YES	NO	
Which is your worst ear?	RIGHT	LEFT	SAME

History of Hearing Loss

(Please Circle One)

Do you hear conversations loud enough, but cannot understand the words?	YES	NO
Do you often ask others to repeat what they just said?	YES	NO
Do you find it difficult to understand conversations in noisy places?	YES	NO
Do others say you play the TV or radio to loud?	YES	NO
Do you have trouble understanding some people on the telephone?	YES	NO
How many years have you experienced hearing and understanding loss?	_____	
Do you now, or have you ever worn a hearing aid?	YES	NO

IF A HEARING LOSS IS DISCOVERED, ARE YOU READY FOR HELP? YES NO

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