Patient Information Form

Patient Information

- ☐ Mr.
- ☐ Mrs.
- ☐ Ms.

Name: ____ Date of Birth: ______________

Address: ____________________________________ Phone: ______________________________

____ Email: ______________________________

Primary Physician & Location: ________________________________ Insurance: _________________

Alternate Contact & Relationship: ______________________________ Phone: _________________

How did you hear about LHC? ____

Hearing Health History

1. Have you ever had treatment or surgery for an abnormal condition of the ear? **YES / NO**
   - If yes, which physician treated you? ________________________
   - Date: __________
2. Have you ever had your hearing screened/tested? **YES / NO**
   - Was a hearing loss indicated? **YES / NO**
   - If yes, estimate date (MM/YYYY): __________

Survey -
Please help us find out what is important to you by filling out this survey. This will provide us information about your hearing health needs and lifestyle priorities.

	Least Difficulty				Greatest Difficulty
1. Hearing the TV clearly	1	2	3	4	5
2. Hearing conversations on the telephone	1	2	3	4	5
3. Hearing conversations in a small group	1	2	3	4	5
4. Hearing conversations in noise	1	2	3	4	5
5. Hearing in crowds	1	2	3	4	5
6. Hearing in a lecture environment (church or guest speaker)	1	2	3	4	5
7. Hearing at your work location	1	2	3	4	5
8. Hearing at home	1	2	3	4	5
9. Hearing young children clearly	1	2	3	4	5
10. Hearing your spouse or loved one	1	2	3	4	5

- ➢ May we send a copy of your test results to your family physician? **YES / NO**
- ➢ Please tell us why it is important for you to have an appointment with us today:

  ____