Hearing Solutions of Louisiana, LLC

1327 Stelly Lane, Suite C, Sulphur, LA 70663 (337) 528-7842

Patient Name: _____ Social Security Number: _____

Date of Birth: _____ Gender: Male or Female Marital Status _____

Address _____City _____State _____ Zip _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Primary Insurance _____ Policy & Group# _____

Name & Date of Birth of Policy Holder _____

Secondary Insurance _____ Policy & Group # _____

Name & Date of Birth of Policy Holder _____

Spouse or Responsible Party_____ SS# _____ Date of Birth_____

Employer _____ Occupation _____

Employer's Address_____ City _____ State _____ Zip _____

Email Address: _____

Nearest Relative NOT Living at Same Address _____ Relation _____

Home Telephone _____ Alternate Telephone (Cell) _____

AUTHORIZATION FOR ASSIGNMENT OF INSURANCE CLAIMS AND RELEASE OF MEDICAL RECORDS IS HEREBY GIVEN. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE.

_____

Signature Date

Family Physician: _____

Who may we thank for referring you? _____

Reason for your visit today?

_____

Where would you like us to send a copy of your results? _____

Who may we discuss your results with? _____

GENERAL INFORMATION

Do you think you have a hearing problem? … YES … NO

If yes, how long have you noticed this problem? _____

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

Was the onset gradual or sudden? _____

In which ear do you hear the best? … Same in both ears … Right … Left

Is your hearing better some days than others? … YES … NO

Have you ever been exposed to loud noises? … YES … NO

If yes, please describe: _____

Does anyone in your family have hearing loss? … YES … NO

If so, who? _____

Have you ever had your hearing tested? … YES … NO

If yes, when? _____

What were the results? _____

MEDICAL INFORMATION

Have you ever had medical/surgical treatment for your ears? … YES … NO

Do you frequently feel dizzy or lightheaded? … YES … NO

Do you notice any buzzing, ringing or roaring in your ears? … YES … NO

If yes, which ear? … Right … Left How frequent? _____

Have you ever had any of the following? (Please Circle)

… Meningitis … scarlet fever … seizures … vision problems … arthritis
… Measles … tuberculosis … injury to head … allergies … depression/anxiety
… Mumps … diabetes … high fevers … pacemaker
… Communicable disease … high blood pressure

Please list any medications (including non-prescriptions) you are currently taking or have taken recently:

_____

_____

Do you have any open sores, bleeding or drainage at this time? … YES … NO

HEARING HISTORY

Do you have difficulty with any of the following?

… Watching TV … Using the telephone
… Meetings … Restaurants
… At the movies … Worship service

Do you have problems hearing any of the following?

… Telephone ring … Doorbell or knocking
… Fire/smoke detector … Sirens
… Alarm clock … Baby cry

Which ear do you use on the telephone? … Right … Left

Are you right or left handed? … Right … Left

Is there any other information related to your hearing you feel might be important for the Audiologist to know?

_____

HEARING AID HISTORY

Have you ever worn a hearing aid? … YES … NO

Do you use a hearing aid now? … YES … NO

If YES, how long have you had a hearing aid? _____

On which ear do you use the hearing aid? … Right … Left … Both ears

Do you wear it regularly? … YES … NO

Do you feel you benefit from it? … YES … NO

List any problems you are having with the hearing aid(s): _____