

Name: _____ Date of Birth: _____

Address: _____

Phone #1 _____ Cell: _____ Email _____

Type of Insurance: _____

- What is the primary reason that you have come here for this evaluation?

- What questions or problems would you like to address today?

MEDICAL HISTORY

- ❖ Date of most recent medical examination: _____
- ❖ Physician's Name: _____
- ❖ How would you describe your general health: _____
- ❖ Have you had any of the following illness? Indicate dates/medications:

↓		Date(s)	Medications
	Diabetes		
	Kidney problems		
	Cancer		
	Allergies		
	Head Injury		
	Heart Problems		
	Arthritis		
	Ear Infections/Surgeries		
	Asthma		
	Autoimmune problems		

Patient Name: _____

Date: _____

AUDITORY/VESTIBULAR HISTORY

Do you experience any of the following?

❖ **Hearing difficulty?**

- Left/Right/Both ears (circle one)
- If hearing problems in both, is one ear better than the other? Left/Right/Equal
- How long have you been aware of this problem? _____
- Please check any/all situations in which you have difficulty hearing:

↓	Listening Situations
	Watching TV
	Talking in groups
	Localizing sounds
	Talking on the telephone
	Movies/theater
	Communicating with individuals at a distance
	Discriminating sounds

❖ **Tinnitus**

- Ringing/Buzzing/Humming (circle all that apply)
- High/Low Pitch (circle one)
- Soft/Loud/Fluctuating (circle all that apply)
- Both Ears/Left/Right (circle one)
- Occasional/Constant (circle one)

❖ **Vertigo and/or dizziness?**

- Describe: _____

❖ **Noise Exposure? Noise Trauma?**

- Occupational _____
- Recreational _____
- Military _____

❖ **Headaches?**

- Describe: _____

❖ **Ear Pain?**

- Left/Right/Both (circle one)
- With discharge? _____

❖ **Excessive cerumen (ear wax)? Yes/no (circle one)**

❖ **Is there a family history of deafness and/or hearing loss?**

- Describe: _____

Please read the following statement if you have NOT been referred by your physician:

I have been advised by TAI, Inc./Arizona Audiology Network, LLC, that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing a hearing aid. I do not wish a medical evaluation before purchasing a hearing aid.

Signature: _____ Date: _____

I hereby acknowledge reading/receiving a copy of TAI, Inc./Arizona Audiology Network, LLC's Notice of Patients' Rights.

Patient Name: _____

Date: _____

TAI, Inc./Arizona Audiology Network, LLC
7255 E Tanque Verde Rd., Suite 131
Tucson AZ 85715
520-260-5731

Signature: _____ Date: _____

Patient Name: _____

Date: _____