Tucson Audiologists (TAI), Inc
7255 E Tanque Verde Rd., Suite 131
Tucson AZ 85715
520-260-5731

Name:_____ Date of Birth:_____

Address:_____

City:_____ State_____Zip_____

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 (including childhood)		
	Asthma		
	Autoimmune problems		

Patient Name:_____

Date:_____

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AUDITORY/VESTIBULAR HISTORY

Do you experience any of the following?

- **Hearing difficulty? Yes/No**
  - 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? Yes/No**
  - 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? Yes/No**
  - Describe:_____

- **Antibiotics administered by IV?_Yes/No**_____

-

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- **Noise Exposure or Noise Trauma? Yes/No**
  - Occupational_____
  - Recreational_____
  - Military_____

- **Headaches? Yes/No**
  - Describe:_____

- **Ear Pain? Yes/No**
  - 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? **Yes/No**
  - Describe:_____

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.

Signature:_____Date:_____

Patient Name:_____

Date:_____