Island Audiology llc
Hear Better. Live Better

ADULT
PATIENT INTAKE

Last Name _____ First Name _____ MI _____

Preferred Name _____ Gender _____ Date of Birth _____

Address _____ City _____ State _____ Zip _____

How would you like to be contacted? (Select all that apply)

☐ Primary Phone #_____ ☐Home ☐Work ☐Cell -- OK to Text? ☐Yes ☐No

☐ Secondary Phone # _____ ☐Home ☐Work ☐Cell -- OK to Text? ☐Yes ☐No

☐ Email _____

Current/ Past Occupation: _____ Hobbies: _____

Employment Status: ☐Full Time ☐Part Time ☐Student ☐ Retired ☐Unemployed

Marital Status : ☐Single ☐Married ☐Divorced ☐ Widowed ☐Legally Separated

What Motivated you to come in today? _____

What would you like to get out of today's appointment? _____

How did you hear about us? ☐Online ☐ Physician Referral ☐Patient Referral ☐Newspaper ☐Mailer ☐Yellow Pages

PHYSICIAN INFORMATION

Primary Care Physician: _____ Ph:_____ Fax: _____

Referring Physician (if different from Primary): _____ Ph: _____ Fax: _____

EMERGENCY CONTACT

Name _____ Relationship _____ Phone Number _____

Authorize to release information to contact? ☐ Yes ☐No

Name _____ Relationship _____ Phone Number_____

Authorize to release information to contact? ☐ Yes ☐No

INSURANCE INFORMATION

Primary Insurance:

Insurance Company _____

Subscriber ID# _____ Last 4 of SSN _____

Relationship to Subscriber:

☐Self ☐ Spouse ☐Child ☐ Other _____

(Subscriber info if other than self)

Name_____ Date of Birth _____

Other Health Insurance:

Insurance Company _____

Subscriber ID# _____ Last 4 of SSN _____

Relationship to Subscriber:

☐Self ☐ Spouse ☐Child ☐Other _____

(Subscriber info if other than self)

Name_____ Date of Birth _____

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ADULT
HISTORY FORM

Patient's Name: _____ Date: _____

ABOUT YOUR EARS:
(please check all that apply and give details when indicated)

- ☐ Ear infections or Ear drainage
  - ☐ Both Ears ☐ Right Ear ☐ Left Ear
  - ☐ Past issue ☐ Current Issue
- ☐ Ear pain
  - ☐ Both Ears ☐ Right Ear ☐ Left Ear
  - ☐ Past issue ☐ Current Issue
- ☐ Ear surgeries
  - ☐ Both Ears ☐ Right Ear ☐ Left Ear
  - ☐ Type(s): _____ Date(s):_____
- ☐ Loud noise or music exposure
  - Describe _____
  - Used hearing protection? ☐ Yes ☐ No
- ☐ Sudden hearing loss
  - Date: _____
  - Details: _____
  - Recovered? ☐ No ☐ Partially ☐ Yes
- ☐ Family members born with hearing loss
  - What relation: _____
- ☐ Dizziness or Unsteadiness
  - ☐ No ☐ Yes
  - Have you ever lost your balance and fallen?
  - ☐ No ☐ Yes
  - Vertigo or Spinning:
  - ☐ No ☐ Yes
  - When did the vertigo first start? _____
  - How often? _____ How long it lasts _____
  - Does it occur after a certain event or movement?
  - ☐ No ☐ Yes
  - Have you been evaluated by a physician for the vertigo?
  - ☐ No ☐ Yes
- Have you ever had your hearing tested?
  - ☐ No ☐ Yes What were the results?

_____

HEARING ABILITY:

On a scale of 1-10, with 10 being excellent, how would you rate your current hearing ability?

Poor 1 2 3 4 5 6 7 8 9 10 Excellent

If hearing loss is diagnosed, and it can not be treated medically or surgically, how interested are you in pursuing amplification (e.g. hearing aids)?

Not Motivated 1 2 3 4 5 6 7 8 9 10 Highly Motivated

HEARING DEVICE EXPERIENCE:

Have you ever worn hearing aids? ☐ No ☐ Both Ears* ☐ Right Ear Only* ☐ Left Ear Only*

Do you currently wear hearing aids? ☐ No ☐ Both Ears* ☐ Right Ear Only* ☐ Left Ear Only*

*Please provide additional details (e.g. age of current hearing device or other device info)

_____

TINNITUS:

Do you have tinnitus (ringing in your ears)? ☐ No ☐ Both Ears* ☐ Right Ear Only* ☐ Left Ear Only*

When did the tinnitus start? _____

Is your tinnitus: ☐ Constant ☐ Intermittent (if so, how often?) _____

What does it sound like? ☐ Ringing ☐ Buzzing ☐ Hissing ☐ Crickets ☐ Other _____

On a scale of 1-10, how bothersome is your tinnitus?

Not Very 1 2 3 4 5 6 7 8 9 10 Extremely Bothersome

MEDICAL HISTORY:

Have you had any of the following?
(please check all that apply and give details when indicated)

- ☐ Alzheimer's disease
- ☐ Bell's Palsy
  Date _____Affected area(s) _____
- ☐ Cancer
  Date(s) _____ Type(s):_____
- ☐ Cardiovascular issues
- ☐ Chemotherapy
  Date(s) _____ Type(s):_____
- ☐ Chicken Pox
  Date (or age) _____
- ☐ Complete loss of sight
  ☐ Both Eyes ☐ Right Eye ☐ Left Eye
- ☐ Compromised Immune System
- ☐ COVID-19
  Date of diagnosis _____
- ☐ Dementia
- ☐ Dexterity issues in hands
- ☐ Diabetes
- ☐ Head Injury
  Date(s) _____ Type(s):_____
- ☐ High Blood Pressure
- ☐ HIV / AIDS
  Date of diagnosis _____
- ☐ Measles
  Date (or age) _____
- ☐ Memory problems
- ☐ Meningitis
  Date _____ Type _____
- ☐ Neurological symptoms
  Describe _____
- ☐ Pacemaker
- ☐ Parkinson's disease
- ☐ Radiation
  Date(s) _____ Type(s): _____
- ☐ Shingles
  Date(s) _____ Affected area(s) _____
- ☐ Sinusitis
- ☐ Stroke or TIA
  Date(s) _____ Type(s): _____
- ☐ TMJ

MEDICATION LIST:

Please list medications or over-the-counter drugs that you take, and what condition they treat.

_____

QUESTIONNAIRE:

Please answer the following questions.

1. How often do you have difficulty hearing clearly when using the telephone?
   ☐ Frequently ☐ Sometimes ☐ Rarely
2. How often do you have difficulty hearing clearly when watching television or streamed shows?
   ☐ Frequently ☐ Sometimes ☐ Rarely
3. How often do you have difficulty hearing clearly when conversing in restaurants?
   ☐ Frequently ☐ Sometimes ☐ Rarely
4. How often does your hearing limit your personal life or social life?
   ☐ Frequently ☐ Sometimes ☐ Rarely
5. How often does your hearing cause you to need people to repeat to you?
   ☐ Frequently ☐ Sometimes ☐ Rarely
6. How often do you have difficulty hearing clearly in the presence of background noise?
   ☐ Frequently ☐ Sometimes ☐ Rarely
7. How often do you have difficulty hearing clearly when listening to women's or children's voices?
   ☐ Frequently ☐ Sometimes ☐ Rarely
8. How often does your hearing cause you to hear people speak, but not understand clearly what they are saying?
   ☐ Frequently ☐ Sometimes ☐ Rarely
9. How often does your hearing cause you to feel as though other people are mumbling?
   ☐ Frequently ☐ Sometimes ☐ Rarely
10. How often does your hearing cause you to feel stressed or tired after listening for a long time?
    ☐ Frequently ☐ Sometimes ☐ Rarely