Patient Intake

MetroHearing
Premium hearing since 1980
A HearingLife Company

PERSONAL

Today's Date / / Gender: ☐ Male ☐ Female ☐ Other

Name: DOB: / /

Address:

City: State: Zip:

Phone: Home ( ) Cell ( )

Email:

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact Phone ( )

INSURANCE

Primary Insurance

Can be found on the back of your insurance card.

Primary Insurance Company | Phone Number | Member ID#

Name of Policyholder | Policyholder Date of Birth

Secondary Insurance

Secondary Insurance Company | Phone Number | Member ID#

Name of Policyholder | Policyholder Date of Birth

HEARING

Do you have difficulties hearing?	☐ Yes	☐ No		
If so, how long? ☐ Less than a year ☐ 1-2 years	☐ 3-5 years	☐ 5-10 years	☐ 10+ years	
Have you ever had a hearing test?	☐ Yes	☐ No		
Do you wear or have you ever worn hearing instruments?	☐ Yes	☐ No		
Do you hear but not understand conversation?	☐ Yes	☐ No	☐ Sometimes	
Do you have difficulty hearing television?	☐ Yes	☐ No	☐ Sometimes	
Do you have difficulty hearing on the phone?	☐ Yes	☐ No	☐ Sometimes	
Do you experience dizziness or balance issues?	☐ Yes	☐ No	☐ Sometimes	
Do you have difficulty hearing in religious services or in small meetings?	☐ Yes	☐ No	☐ Sometimes	

Medical History

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Patient

Name: _____ Date: / /

Medical History

(If any responses are "Yes", enter more information in Notes section below.)

Have you ever been treated by a physician for hearing or ear problems? ☐ Yes ☐ No
Have you seen a physician specializing in diseases of the ear? ☐ Yes ☐ No
Have you ever had any type of ear surgery? ☐ Yes ☐ No
Have you ever worked in noise? ☐ Yes ☐ No
Does anyone in your family have difficulty hearing? ☐ Yes ☐ No

Medical History *(check all that apply)*

☐ Pacemaker ☐ Ringing in the ears/head noises ☐ Vision difficulty
☐ Defibrillator ☐ Blood thinner use ☐ Other – see Notes

Current Medical Conditions *(check all that apply)*

☐ High blood pressure ☐ Thyroid problems ☐ Diabetes ☐ Other- see Notes

Physician _____

FDA Questions

This section to be completed by the Clinician.

☐ Yes ☐ No Visible congenital or traumatic deformity of the ear.
☐ Yes ☐ No History of active drainage from the ear within the previous 90 days.
☐ Yes ☐ No History of sudden or rapidly progressive hearing loss within the previous 90 days.
☐ Yes ☐ No Acute or chronic dizziness.
☐ Yes ☐ No Unilateral hearing loss of sudden or recent onset within the previous 90 days.
☐ Yes ☐ No Audiometric air-bone gap >15dB at 500 Hertz (Hz), 1,000 Hz, and 2,000 Hz.
☐ Yes ☐ No Visible evidence of significant cerumen accumulation or a foreign body in the ear canal.
☐ Yes ☐ No Pain or discomfort in the ear.

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Notes

This section to be completed by the Clinician.

Audibility Index % Functional Test Measure %

Ototoxic medication history: