Duncan Hearing Healthcare

Fall River
1822 N. Main St • Ste 201 • Fall River, MA 02720
P: 508.674.3334 • F: 508.674.5855

Hyannis
745 Falmouth Road • Hyannis, MA 02601
P: 508-862-0255 • F: 508-862-0299

Patient Information

Patient Name: (Last) (First) Date:

Gender: Male ☐ Female ☐ Marital Status: Married ☐ Single ☐ Widowed ☐ D.O.B.: / /

Home Phone: SS#: - -

Cell Phone: Work Phone: EXT:

Occupation: Prior ☐ Current ☐

Mailing Address: Apt/Suite:

City: State: Zip:

Email:

Emergency, Contact: Phone:

Relation to Patient:

Primary Care Physician: Phone:

How did you hear about us?

☐ Mail ☐ Call ☐ Employer ☐ Fair Health/ Senior
☐ Yellow Pages ☐ Radio ☐ Referred by Friend:
☐ Newspaper Ad ☐ Website ☐ Referred by Physician:
☐ Sponsored Event ☐ Insurance ☐ Other:

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Do you have Insurance? **Yes / No** Do you have Medicare? **Yes / No**

Name of Policy Holder:

Policy Number: Group Number:

Patient Agreement

☐ The FDA has determined that is in my best interest to have a medical evaluation by a licensed physician (preferably a physician who specialized in diseases of the ear) before purchasing hearing instruments. I have been advised by my hearing healthcare professional and/or his or her agents about this determination and hereby waive this requirement.

☐ I give permission to my hearing healthcare professional to release information–verbal and written, contained in my medical records and other documents–to my insurance company, rehab nurse, case manager, attorney, employer, healthcare providers, assignees and/pr beneficiaries and all other relevant persons. Information that does not identify me as the patient may be used for quality purposes.

☐ I acknowledge that I agree that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchase made.

☐ I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.

☐ I hereby authorize the transfer of my records to be released to Duncan Hearing Healthcare.

Signature_____ Date _____

Signature_____ Date _____

SIGNATURE OF PARENT OR GUARDIAN IF PATIENT IS A MINOR

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Name: (Last) (First) Age: Date:

1. What is the primary reason for today's visit:

2. Are you experiencing problems with your hearing? **Yes / No**

   Which ear? **Both / Right / Left**

3. Has the hearing loss been: **Gradual / Sudden / Fluctuating**

4. How long have you noticed problems with your hearing?

   Recently / 1-3 / 4-6 / 7-10 / More than 10 Years

5. What do you think may have caused this?

6. Have you had your hearing tested before? **Yes / No**

   If yes, when:

7. What was the outcome of your previous hearing test?

   No loss / Mild loss / Hearing aids recommended

8. Do you currently use a hearing aid? **Yes / No**

9. Have you ever used a hearing aid(s)? **Yes / No**

10. Do any members of your family have a hearing problem? **Yes / No**

11. Do you have a history of ear infections? **Yes / No**

12. Have you had any of the following in the last six months?

    (Circle all that apply) **Medically diagnosed ear pathology / Ear pain**
    Pressure or fullness in the ears / Ear drainage

13. Have you had surgery on your ears? **Yes / No**

    If Yes, Which ear? **Both / Right / Left**

14. Do you hear noises in your ears or head? (Tinnitus) **Yes / No**

    Which ear? **Both / Right / Left**

    If Yes, how often do you hear these noises?

    Constantly / Frequently / Occasionally / Very Seldom

15. How would you describe the noise?

    Ringing / Buzzing / Roaring / Screeching / Crickets / Pulsating

16. Are you experiencing any problems with dizziness? **Yes / No**

    If Yes, is your dizziness accompanied by the following? (Circle all that apply)

    Nausea / Vomiting / Noises in your ears / Loss of Consciousness

Doctor Notes:

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17. Do you have or have you had any of the following? (Circle all that apply)

Sinuses/Allergy	**Meningitis**	**Mumps**
Measles	**Thyroid**	**Diabetes**
Stroke	**Heart Attack**	**High Blood Pressure**
Head Injury	**Arthritis**	**Appetite Change**
AIDS/HIV	**Cancer**	**Blood Disorder**
High Cholesterol	**Chicken Pox**	**Diphtheria**
Encephalitis	**Fatigue**	**Genetic Disorders**
Headaches	**Heart Problems**	**High Fevers**
Scarlet Fever	**Stroke**	**Tonsillitis**
Vascular Problems	**Typhoid**	

Other:

18. Do you take medications regularly? (Please list on sheet provided) **Yes / No**

19. Allergies to medication or plastics?

20. Have you ever been exposed to excessively loud noises? **Yes / No**

21. Are you currently employed? **Yes / No / Retired**

22. What is or was your occupation?

PLEASE CHECK ALL MEDICAL SYMPTOMS THAT APPLY:

23. Eye Problems? (such a s blurred vision or pain): **Yes / No**

24. Nose, throat or mouth problems? **Yes / No**
(such as trouble swallowing, nose bleeds, denture issues, pain)

25. Cardiovascular Symptoms? **Yes / No**
(such as hypertension, chest pain, swelling, palpitations, heart surgery)

26. Respiratory Symptoms? (such as shortness of breath, cough, wheezing) **Yes / No**

27. Gastrointestinal Issues? (nausea, vomiting, weight changes, diarrhea) **Yes / No**

28. Musculoskeletal Symptoms? (such as joint pain, swelling, recent trauma) **Yes / No**

29. Neurological Symptoms? **Yes / No**
(such as numbness, headaches, seizures, muscles weakness)

30. Psychiatric Issues? (such as depression, anxiety, compulsions) **Yes / No**

31. Endocrine Symptoms? (such as frequent urination, hot flashes) **Yes / No**

32. Hematologic / Lymphatic Symptoms? **Yes / No**
(such as bleeding gums, bruising, swollen glands, clotting issues)

33. Allergic / Immunologic Symptoms? **Yes / No**
(such as hives, asthma, itching, immune deficiency)

Doctor Notes: