Plattsburgh Hearing

Client Information Form

Date: _____

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Accompanied to appointment by _____ Relationship _____

Family Physician: _____ Location: _____

Insurance: _____ Member ID# _____

History of Hearing Impairment

Have you received any medical or surgical treatment for hearing loss? . . . . . ☐ Yes ☐ No

Physician who treated you: _____ Phone: _____

Street Address: _____ City: _____ State: _____ Zip Code: _____

Medical History Information

Visible congenital or traumatic deformity of 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 with the previous 90 days? . . . . . ☐ Yes ☐ No

Acute or chronic dizziness? . . . . . ☐ Yes ☐ No

Unilateral hearing loss of sudden or recent onset with the previous 90 days? . . . . . ☐ Yes ☐ No

**Audiometric air-bone gap equal to or greater than 15 decibels at 500, 1000 & 2000 hertz? ☐ Yes ☐ No

**Visible evidence of bleeding, significant cerumen accumulation or foreign body in the ear canal? ☐ Yes ☐ No

Pain or discomfort in the ear? . . . . . ☐ Yes ☐ No

**** If answer is YES to any of the questions above, client must be referred to a physician or ear specialist prior to a hearing aid fitting.**

Will this be the first time you've ever had your hearing tested? . . . . . ☐ Yes ☐ No

If No, when? _____

Do you now or have you ever worn hearing aids? . . . . . ☐ Yes ☐ No

If Yes, where did you purchase them?_____ How many years ago?_____

Consultant Information

Consultant _____ License Number _____

Notes _____

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