Iowa Audiology
ESTABLISHED 1981

Thank you for choosing our office.

In order to serve you properly, we will need the following information. All information will be strictly confidential.

Patient Name _____ DOB _____

Primary Phone # _____ Other Phone # _____

Email Address _____

Mailing Address _____

Marital Status ☐ Married ☐ Single ☐ Widowed

Spouse Name _____

Emergency Contact or Responsible Party _____ Phone # _____

Relationship to Patient _____

Primary Physician Name & Location _____ Phone # _____

How did you hear about us?

☐ Website

☐ Referred by Friend _____

☐ Referred by Physician _____

☐ Retirement Home _____

☐ Mail

☐ Other _____

Hearing Health Assessment

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing?
☐ Within one year ☐ One to five years ☐ Six to 10 years ☐ 10+ years

Did your hearing loss come on ☐ Suddenly ☐ Gradually

Have you utilized hearing devices in the past, or do you currently utilize hearing devices?

☐ Yes ☐ No If yes, describe your satisfaction with them. _____

Which do you feel is your better ear? ☐ Right ☐ Left

Which ear do you most often use on the telephone? ☐ Right ☐ Left ☐ Both ☐ Neither

Do you hear any ringing or other noises in your ears?

☐ Yes ☐ No If yes, which ear and what noises? _____

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawn Mower ☐ Other (describe) _____

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Patient dexterity ☐ Good ☐ Fair ☐ Poor

Patient vision ☐ Good ☐ Fair ☐ Poor

Do you have dizziness or vertigo? ☐ Yes ☐ No

Have you had any earaches, infections or drainage from your ear(s) recently? ☐ Yes ☐ No

History of active drainage from the ear within the previous 90 days? ☐ Yes ☐ No

Pain or discomfort of the ears? ☐ Yes ☐ No

Any medical treatment or surgery on your ears? ☐ Yes ☐ No

Are you diabetic? ☐ Yes ☐ No

Do you have a pacemaker? ☐ Yes ☐ No

Do you have any family history of hearing issues or the use of hearing instruments?

☐ Yes ☐ No If yes, who? _____

What are the top four environments in which you would like to hear better?

1. _____

2. _____

3. _____

4. _____

What would you like to accomplish at today's appointment? _____

_____

Signature

I authorize this office to release any information necessary to expedite insurance claims.
I understand that I am responsible for all charges, regardless of insurance coverage.

Patient or Guardian Signature _____ Date _____