Cedar Rapids
HEARING CENTER
1825 29th St NE, Ste. A., Cedar Rapids, IA 52402
(319) 286-8782

NEW PATIENT CASE HISTORY FORM

PERSONAL INFORMATION

Name _____ **Date of Birth** _____

Address _____
(city) (state) (zip)

Phone _____ **Email** _____

Preferred method of contact (circle one) Phone Email

Emergency Contact _____ **Phone Number** _____

How did you learn about us? Social Search Friend/Family: _____ Other: _____

HEARING HISTORY

When did you first notice you were having difficulty hearing or understanding what you heard? _____

How well do you think you hear? (circle one) Well Fair Poor

Have you had your hearing tested in the past? _____ When? _____ Where? _____

What were the finding/recommendations? _____

Has your hearing loss come upon gradually or suddenly? (circle one) Gradually Suddenly

If suddenly, within the previous 90 days? Yes No **Do you have any dizziness or off-balance sensations?** Yes No

Does your hearing seem to fluctuate? Yes No **Do you have any ringing or other noises in your ears?** Yes No

Does any other member of your family have hearing loss? Yes No If yes, who? _____

Do you have a history of prolonged exposure to loud noises? Yes No

Have you had any earaches, infections or drainage from your ears recently? Yes No

If yes, please explain _____

Have you had any pain or discomfort in your ears recently? Yes No

Have you had any medical treatment or surgery on your ears? Yes No

If yes, please explain _____

Have you had any pressure or fullness in your ears recently? Yes No

Do you have any allergies? Yes No If yes, please explain _____

Are you taking any medications/drugs? Yes No If yes, please explain

Please provide name of your family physician or ENT: _____

Have you seen your doctor within the last six months? Yes No

Do you have insurance for hearing aids? Yes No

Would you like a copy of your test results sent to your physician? Yes No