Amplisound - Confidential Information Sheet

Date _____/_____/_____

Name _____
Address _____
City _____ State _____ Zip _____
Phone _____ Cell _____
Email _____
Person(s) present_____
Physician _____
Address _____

How did you find out about Amplisound?
(Please check all that apply)

☐ Norwich Bulletin
☐ Reminder
☐ Turnpike Buyer/Shopper's Guide
☐ Website/Internet/Facebook
☐ Friend /Family (name) _____
☐ Doctor's Office (name) _____
☐ Other_____

Date of birth _____/_____/_____ Gender: ☐ Male ☐ Female Marital Status: _____
Occupation: _____ Recreation sport/hobby: _____
Family member with hearing problem? _____ Do you hear ringing or noises? _____
How long have you had a hearing problem? _____ Estimate of spouse/family? _____
What do you believe caused your hearing problem?_____
Which is your better ear? _____ Telephone ear? _____ Trouble hearing on the phone? _____
Have you consulted with a physician about your hearing? _____ When? _____
Whom? _____ Results? _____
Date of last hearing test: _____ By whom? _____
Ever worn hearing aids? _____ Brand/style? _____ How long? _____
Results / What would you like to improve? _____
Do you have trouble hearing: ☐ TV ☐ Worship Services ☐ In Theatres ☐ At Meetings ☐ In Groups ☐ In Noise
Other situations? (explain) _____
Has your hearing problem caused difficulties: ☐ At work ☐ At home ☐ Socially
Why haven't you investigated your hearing problem before today? _____
General Health: _____ Medications: _____

OFFICE USE ONLY - DO NOT WRITE BELOW THIS AREA

1. ☐ YES ☐ NO Visible congenital or traumatic deformity of the ear? Describe _____
2. ☐ YES ☐ NO Visible accumulation of cerumen or other foreign body in ear canal?
3. ☐ YES ☐ NO Active drainage from either ear within previous 90 days?
4. ☐ YES ☐ NO History of sudden or rapidly progressive hearing loss within previous 90 days?
5. ☐ YES ☐ NO Acute or chronic dizziness within previous 90 days?
6. ☐ YES ☐ NO Sudden or recent onset of unilateral hearing loss within previous 90 days?
7. ☐ YES ☐ NO Pain or discomfort in either ear?
8. ☐ YES ☐ NO Air/Bone gap greater than or equal to 15dB at 500Hz, 1000Hz, and 1500Hz?

Testing performed by: _____ Location: _____

☐ Patient referred to physician ☐ Medial Clearance on file ☐ Patient signed medical waiver

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