Adult Form

PERSONAL INFORMATION

NAME: Dr./Mr./Mrs./Ms._____D.O.B:_____

ADDRESS:_____

_____

TEL. #:
(home)_____(work/alternate)_____

Email_____

FAMILY PHYSICIAN:_____

_____

Release to send report? _____Yes _____ No

Consent to administer tests/treatment ____Y ____N

INSURANCE

OHIP: _____

THIRD PARTY (ex. Green Shield): Insurance company name:_____

_____

Policy #: _____

_____

WSIB claim #_____

DVA# (specify Group A or B please):_____

MEDICAL HISTORY

1.Briefly describe the main purpose of this visit:_____

_____

2. Have you had a previous Hearing Test? Date:_____ Yes No

3.Do you think that you are having any difficulties hearing? Yes No
If yes, which ear (circle) **RIGHT LEFT BOTH UNSURE**

If yes: Approx. how long have you been having difficulties? _____

4.Do you think that your difficulty hearing has started SUDDENLY or GRADUALLY? (circle)

5. IF YOU HAVE HEARING PROBLEMS ANSWER:
a. Ae your difficulties worse in noisy environments? Yes No
b.Do you require people to repeat themselves often? Yes No
c. Do you require the tv louder than others find comfortable? Yes No

6. Is there a family history of hearing loss? Yes No

7.Do you hear ringing or noises in your ears? Yes No
If 'yes': Which ear (please circle)? **Right Left Both Unsure**

8. Do you or have you ever worn hearing aid(s)? Yes No
If Yes: Which ear? (circle) **Right Left Both**

9. Do you have problems with ear wax build-up? Yes No

10. Have you ever been exposed to loud noises/sounds? Yes No
(ex. Work, music, hunting, etc.)

11. Do you suffer from chronic ear infections? Yes No
If yes: do your *ears drain* fluid? **Yes no**

12. Do you have ear pain? Yes No
If 'yes': Which ear? **Right Left Both**

MEDICAL HISTORY

13. Do you have problems with dizziness? Yes No

If 'yes": How long does each episode last (please circle)?

Seconds Minutes Hours Days

If yes: Does **movement** cause the dizziness to occur (ex. Rolling over in bed**)?**

Yes No

14. Do you suffer from migraines or chronic headaches? Yes No

15. Have you ever had *ear* surgery? Yes No

If 'yes': Briefly describe_____

16.Have you ever had a head injury with internal bleeding? Yes No

17. Are you diabetic? Yes No

18. Do you have heart problems including high blood pressure? Yes No

19. Do you have any allergies to latex or plastic? Yes No

20. Do you have any problems with your jaw (ex. TMJ)? Yes No

How did you *hear* about us (please circle)? Friend/Family – Name:_____

Doctor Referral Newspaper Mail Drop Yellow-pages

Website The Drive Windsor Life OTHER