Patient Demographic Form

Name: _____ Date of Birth: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Please circle all that apply: Male/Female Employed/Retired/Other Married/Single/Other

Companion/Relative Name: _____ Phone: _____

May we discuss your care with this person? **YES / NO** (Patient Initial_____)

Primary Doctor: _____ Phone: _____

Referring Physician: _____ Phone: _____

Referring Physician Address: _____

Would you like your results sent to your family doctor? **YES / NO** (circle one)

How did you hear about us? Referred By: Doctor: _____ (Name) Friend: _____ (Name)

Newspaper: _____ (Name of Paper) Mailing: _____ (Type) Other: _____ (Yellow Pages, Internet, Signage, Outreach)

Have you had your hearing tested? **YES / NO** If yes, how long ago? _____

Do you currently wear hearing aids? **YES / NO** If yes, when did you purchase them? _____

Have you been having trouble hearing recently? **YES / NO**

Who suggested you have a hearing test: _____

Please check or circle all that apply: Use empty boxes for other conditions not listed

Ear Pain **R L**	Running Ears **R L**	Surgery **R L**	Tubes **R L**	Infections **R L**	
Ringing in ears **R L**	High Pitch **R L**	Noise in the head			
Vertigo	Balance issues	Room Spinning	Sense of spinning	Turning head worsens spinning	Recent Fall
Chemotherapy	Radiation	Water Pills	Blood Thinners		
Diabetes	Cardiovascular issues	Stroke	Head Injury		
Noise Exposure:	Work	Military	Farming		
History of hearing loss:	Mother	Father	Sibling	Grandmother	Grandfather
History of Dementia/ Forgetfulness:	Mother	Father	Grandmother	Grandfather	