

NEW PATIENT

INTAKE FORM



1408 I-70 Dr. SW #102, Columbia, MO 65203

PATIENT INFORMATION

PATIENT NAME: _____ **DOB:** _____

Address: _____

Phone: _____ Sex: Male Female

Email Address: _____

Is it ok to send appointment updates via email?: YES NO Text?: YES NO

Secondary Contact Name: _____ Phone: _____

INSURANCE: _____

FDA RED FLAGS (OFFICE USE ONLY)

- Yes No Visible congenital or traumatic ear deformity?
- Yes No History of active drainage from the ear within the past 90 days?
- Yes No Pain or discomfort in the ear?
- Yes No Acute or chronic dizziness?
- Yes No History of sudden or rapidly progressive hearing loss within the past 90 days?
- Yes No Unilateral hearing loss of sudden or recent onset within the past 90 days?
- Yes No Visible evidence of significant cerumen accumulation or a foreign body in the ear canal?
- Yes No Audiometric air-bone gap equal to or greater than 15 dB at 500, 1000, and 2000 Hz?

PTA	2K	SRT	MCL	UCL	WR	%	Quick SIN
R	R	R	R	R	R	R	
L	L	L	L	L	L	L	
			B	B	B	B	

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HEARING HEALTH QUESTIONNAIRE (OFFICE USE ONLY)

GENERAL HEARING ABILITY

- Yes No Do you have trouble hearing in noisy environments? (e.g., restaurants, crowded rooms)
- Yes No Do you frequently ask people to repeat themselves?
- Yes No Is it difficult to understand conversations when multiple people are talking at once?
- Yes No Do you have trouble hearing women and children's voices?
- Yes No Do you find yourself turning up the volume on the TV or radio louder than others?
- Yes No Do you have trouble hearing on the telephone?
- Yes No Do you feel like people are mumbling when they speak?
- Yes No Do you have difficulty understanding speech in quiet environments?
- Yes No Do you experience ringing or buzzing in your ears (tinnitus)?

IMPACT ON DAILY LIFE

- Yes No Do you feel frustrated or embarrassed by your hearing difficulties?
- Yes No Do you avoid social situations or activities due to your hearing?
- Yes No Has your hearing affected your personal or professional relationships?
- Yes No Do you feel limited or restricted by your hearing loss?

OTHER QUESTIONS

- Yes No Have you ever been exposed to loud noises (e.g., loud music, construction, firearms)?
- Yes No Do you have any family history of hearing loss?
- Yes No Do you have any other medical conditions that might affect your hearing?
- Yes No Do you experience dizziness or pain in your ears?