CLEAR CHOICE
AUDIOLOGY, LLC.

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Adult Registration:

Patient's Name: _____ Birthdate: _____
First M.I. Last

Address: _____ SSN: _____ Sex: _____

City: _____ State: _____ Zip: _____ Phone: _____

Family Physician: _____ Referring Physician: _____

History: (Circle/Check answers below)

Have you had your hearing tested before? Yes No Where, and results_____

Do you have a hearing loss? Yes No Unsure (If yes, Right Left Both)

How long? ____Recently (within 90 days) ____ Less than 1 year ____ Over 1 year ____ 5+ years

Could your hearing loss have been caused by medication? Yes No Unsure If yes, type _____

Do you have noises in your ears? Yes No (If yes, Right Left Both)

Do you have pain in your ears? Yes No

Any ear surgery or medical problems with your ears? Yes No

Is there a history of hearing loss in your family? Yes No

Have you had dizziness or difficulty with your balance? Yes No

Have you been exposed to loud noise for extended periods? Yes No

If yes, what type of noise? _____

Do you have difficulty hearing in the following situations: ___ In the car ___ TV/Radio ___ Church

___ Restaurants ___ In quiet situations ___ Small groups ___ Telephone ___ Other _____

If we find through our evaluation that we can help you, are you ready for the help? Yes No

Hearing Instruments: Yes No

If yes, what type _____ Are you satisfied with your current device? _____

In what situations would you like to hear better? _____

Comments: _____