McCoy Institute of Hearing & Balance
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PATIENT INTAKE FORM

Patient Name: _____/_____/_____ Preferred Name: _____ Date: _____
First M.I. Last

Title: ☐ Mr. ☐ Mrs. ☐ Ms. ☐ Miss ☐ Dr. ☐ Other: _____

Street Address: _____

City: _____ State: _____ Zip: _____ Social Security #: _____

Phone: (H) _____ (C): _____ (W) _____

Date of Birth: _____ Male or Female E-Mail: _____

Occupation/Student: _____ If retired, what type of work did you do? _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Partnered

Emergency contact/Relationship: _____ Phone: _____

Name of Family Physician: _____ Phone: _____

Permission to release copy of test information to Physician? _____ Yes _____ No

How did you hear about us? ☐ Mail ☐ Phone ☐ Radio ☐ Newsletter
☐ Web ☐ TV ☐ Physician ☐ Yellow Pages
☐ Referral ☐ Other: _____

CONFIDENTIAL PATIENT INFORMATION

MEDICAL HISTORY

Will this be your first hearing test? ☐ Yes ☐ No
If no, when was your last test? _____

Has an ear physician examined you in the last 6 months? ☐ Yes ☐ No
Have you ever had ear surgery? ☐ Yes ☐ No
Do you have a history of ear infections? ☐ Yes ☐ No
Do you have a history of exposure to loud noises? ☐ Yes ☐ No

Do you have any family history of hearing loss? ☐ Yes ☐ No

Do you have any of the following?

- Deformity of the ear? ☐ Yes ☐ No
- Ear Drainage? ☐ Yes ☐ No
- Sudden or rapid hearing loss during the last 90 days? ☐ Yes ☐ No
- Acute or recurring dizziness? ☐ Yes ☐ No
- Ear pain? ☐ Yes ☐ No
- Wax removed by a doctor? ☐ Yes ☐ No
- Ringing in the ears? ☐ Yes ☐ No

HEARING HISTORY SURVEY:

- Do you have difficulty understanding speech in a group of people? ☐ Yes ☐ No
- Do you often ask that statements, questions and directions be repeated? ☐ Yes ☐ No
- Do you hear people speaking but have difficulty understanding the words? ☐ Yes ☐ No
- Do others raise their voices or move closer to help you hear them? ☐ Yes ☐ No
- Do you turn the television up louder than normal to hear clearly? ☐ Yes ☐ No
- Do you ever have to concentrate so intently to hear that you tire from it? ☐ Yes ☐ No
- Do you ever avoid situations because of your hearing problems? ☐ Yes ☐ No
- Do you have difficulty understanding conversations on the phone? ☐ Yes ☐ No
- Do you hear some people better than other? ☐ Yes ☐ No
- Do you feel safe with your ability to hear sounds outside of your home? ☐ Yes ☐ No
- Do you have particular difficulty understanding children? ☐ Yes ☐ No

In what one situation would you most like to hear and understand?

_____

If we find through the consultation that you can be helped,
are you ready to move forward with that help? ☐ Yes ☐ No

Do you presently own hearing aids? ☐ Left ☐ Right ☐ Both ☐ None

If so, Make: _____ Model: _____ Year Purchased: _____

You are here today because: _____

_____

Patients Signature: _____

Tested by: _____ License#: _____