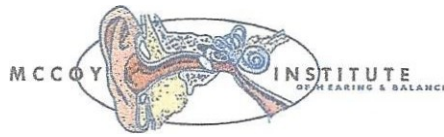


McCoy Institute of Hearing & Balance
5114 San Juan Ave.
Jacksonville, FL. 32210
Phone: 904.318.3763
Fax: 904.212.0665
Web: www.mccoyinstitute.org



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#: _____