Patient Demographic Form

The Place for Better Hearing
3302 Westbourne Drive
Cincinnati, OH 45248

Patient Information

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: ______________

Primary Doctor: ______________________________ Phone: ______________

Referring Physician: ______________________________ Phone: ______________

Referring Physician Address: ____

Would you like your results sent to your family doctor? Y / N (circle one)

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

Newspaper: ______________ (Name of Paper) Mailing: ______________ (Type) Other: ______________ (YellowPages, Internet, Signage, Outreach)

Alternate Contact: ______________ Relationship to Patient: ______________ Phone: ______________

May we discuss your care with this person? ____ yes _____ no (Patient Initial______)

Have you been having trouble hearing recently? YES / NO. If yes, when did it begin? _____ Years ago, or, _____ Months ago.
Do you currently wear hearing aids? YES / NO. If yes, when did you purchase them? ______________

Do you have any of the following? (PLEASE CIRCLE ALL THAT APPLY):

Acute or recurring dizziness	Sudden or recent hearing loss	Ear drainage	Ear pain	Punctured eardrum
Ear pressure or fullness	Ears popping	Diabetes	Skin problems	Allergies

Have you ever seen a physician concerning an ear problem? YES / NO. If Yes, how long ago? ____Years ago. What was the nature of the problem? ______________________________. Was surgery performed? YES / NO.

Do you have tinnitus (ringing or noise in ears or head)? YES / NO. If yes, for how long? ____________.
Is it (please circle): CONSTANT / INTERMITTENT / EQUAL IN BOTH EARS / MORE IN ONE EAR / ONLY IN ONE EAR

Have any of the following blood relatives had *any degree* of hearing difficulty? (PLEASE CIRCLE ALL THAT APPLY):

Mother	Mother's mother	Mother's father	Mother's sibling(s)	Sister
Father	Father's mother	Father's father	Father's sibling(s)	Brother

Does your spouse or partner have hearing difficulty? YES / NO. Does your child(ren) have hearing difficulty? YES / NO.

Have any of the above mentioned individuals had hearing aids? YES / NO.

Have any blood relatives have permanent hearing loss beginning in childhood? YES / NO. Ear surgeries? YES / NO.

Have you had noise exposure from? (PLEASE CIRCLE ALL THAT APPLY):

Work noise	Military	Factory	Truck driving	Wood working	Races
Farming	Landscaping	Loud music	Shooting	Fireworks	Other: ________

Hearing Handicap Inventory Screening Questionnaire for Adults

1) Answer **No**, **Sometimes** or **Yes** for each question.

2) Do not skip a question if you avoid a situation because of a hearing problem.

3) If you use a hearing aid, please answer according to the way you hear with the aid.

	No	Sometimes	Yes
1. Does a hearing problem cause you to feel embarrassed when you meet new people?	0	2	4
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?	0	2	4
3. Do you have difficulty hearing / understanding co-workers, clients or customers?	0	2	4
4. Do you feel handicapped by a hearing problem?	0	2	4
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	0	2	4
6. Does a hearing problem cause you difficulty in the movies or in the theater?	0	2	4
7. Does a hearing problem cause you to have arguments with family members?	0	2	4
8. Does a hearing problem cause you difficulty when listening to TV or radio?	0	2	4
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	0	2	4
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	0	2	4
Totals:			

* Adapted from: Ventry, I., Weinstein, B. "Identification of elderly people with hearing problems" American Speech-Language-Hearing Association. 1983, 25, 37-42. *

Interpreting the Raw Score:

Name: ______________________________ Date: ________________