San Francisco Hearing Center

AUDIOLOGICAL SERVICES OF SF
3150 California St, Suite 1
San Francisco, CA 94115
Phone: 415-386-3446

PATIENT HISTORY & INTAKE FORM

Patient ______________________________ Birthdate _____________ Date _______________
(please print)
Home Phone__________________________ Mobile Phone _____________________________

Email address ____

Mailing Address ____

Emergency contact________________________________Phone_________________________

1. Reason for today's visit:

2. Referred by:

3. Primary care physician:

4. Have you had any of the following conditions? If YES, briefly explain.
   ☐ Kidney Disease ☐ Diabetes ☐ Cancer ☐ Hypertension
   ☐ Head Trauma/Concussion ☐ Surgery on your ear(s), nose or throat
   Additional Comments:

5. List all medications you are currently taking:

Medication name:	Dose:	Medication name:	Dose:

9. When did you first notice your hearing problem?

10. Was your change in hearing SUDDEN or GRADUAL? ☐ Sudden ☐ Gradual
11. Has your hearing become worse since you first noticed the problem?
    ☐ Yes ☐ No
12. Do you hear better in one ear than the other?
    ☐ Yes, right ear is better ☐ Yes, left ear is better ☐ No
13. Does your hearing REMAIN CONSTANT or FLUCTUATE?
    ☐ Remains Constant ☐ Fluctuates

14. Have you experienced any recent or current ear pain?
☐ Yes, both ears ☐ Yes, left ear only ☐ Yes, right ear only ☐ No
15. Do your ears feel plugged?
☐ Yes, both ears ☐ Yes, left ear only ☐ Yes, right ear only ☐ No
16. Are you experiencing any ringing, buzzing, or other noises in your ears?
☐ Yes, both ears or "in-head" ☐ Yes, left ear only ☐ Yes, right ear only ☐ No
17. Have you experienced any dizziness/vertigo? If YES, briefly explain and note if current or past.
☐ Yes ☐ No
Additional Comments:

18. Have you ever been exposed to loud noise (work, recreation, military service)? If YES, briefly explain.
☐ Yes ☐ No
Additional Comments:

19. Do you use tobacco?
☐ Yes ☐ No
20. Has anyone in your family experienced hearing loss? If YES, who and at what age?
☐ Yes ☐ No Who/what age:_____________________________________
21. In which situations do you have difficulty hearing?

22. On a scale from 1 to 10, 1 being the worst and 10 being the best, how would you rate your overall hearing ability?

1	2	3	4	5	6	7	8	9	10
worst									**best**

23. Have you had your hearing tested before? If YES, briefly explain (where/when).
☐ Yes ☐ No
Additional Comments:

24. Have you ever worn hearing instruments? If YES, briefly explain.
☐ Yes, currently ☐ Yes, in the past ☐ No
Additional Comments:

30: Insurance:

I authorize payment of medical benefits directly to the providers for services rendered. I also authorize the release of medical or other information needed to process the claim.

Signature ____ Date ____________________