Hearing Care Centers

"Care is our middle name"

West Hartford
Bristol
Torrington

Patient Information Form

Patient Name: _____
First Intial Last

Date of birth: _____ Sex: M ○ F ○

Home Phone: _____ Cell Phone: _____

Mailing Address: _____
Street City State Zip

Marital Status: ○ Married ○ Single ○ Divorced ○ Widowed ○ Domestic Partner

Spouse or Partner'sName: _____ Email Address: _____

Nearest Relative Name and Phone: _____

Primary Care Physician Name and Phone: _____

Occupation: _____ If retired what work did you do? _____

Hearing Health History

Have you ever or do you;
Please answer yes or no.

Deformity of the ear _____ Hearing loss in one ear in the last 90 days _____
Drainage from either ear _____ Sudden or rapid hearing loss in the last 90 days _____
Sudden or long term dizziness _____ Ever seen a doctor for wax removal _____
Pain in ears _____ Which ear is your poorer ear _____
Do you have problems understanding words in conversations clearly? _____
Hearing in a crowd or other situations where background noise is present? _____
Does anyone in your family have a hearing problem? _____ If yes whom? _____
Do you have difficulty on the telephone? _____
Have you ever worn a hearing aid? _____ If yes what brand? _____
How long have you had your hearing problem? _____
Would you accept help for your hearing problem? _____
In what circumstances do you have the most difficulty hearing? _____
Are you taking any medications? _____ If yes please give a list to your provider.
How did you hear about us? _____

Signature: _____ Date: _____