GTH

GOTOHEARING.COM

Patient Intake Form

PATIENT INFORMATION

Name: Date of Birth:

Street Address:

City: State: Zip Code:

Home Phone Number: Mobile Phone Number:

Email: Occupation:

Name of Accompanying Party: Relationship:

MEDICAL HISTORY

Certain types of medication can impact hearing or may complicate taking an impression of your ear. Do you take any of the following types of medication? If so, please check the appropriate box(es) and list.

☐ Blood Thinners ☐ Heart Medications ☐ Insulin ☐ Chemotherapeutic ☐ Pain Relievers

As part of your hearing evaluation, you may come into contact with various materials. Are you allergic to any of the following? ☐ Latex ☐ Nitrile ☐ Plastics ☐ Rubber ☐ Silicone ☐ Other ____________

Have you ever had medical/surgery treatment for your ears? ☐ Yes ☐ No

If yes, at what age? ____________ Type of surgery/treatment: ____________

Check any of the following conditions if you currently have or have had in the past.

☐ Arthritis
☐ Allergies
☐ Bell's Palsy
☐ Concussion/Skull Fracture
☐ Depression/Anxiety
☐ Cancer
Type/Treatment: ____________

☐ Diabetes I or II
☐ Hepatitis
☐ High Blood Pressure
☐ High Fever
☐ HIV
☐ Measles/Mumps
☐ Meniere's

☐ Meningitis
☐ Multiple Sclerosis
☐ Neuropathy
☐ Pacemaker
☐ Parkinson's Disease
☐ Memory Issues
Diagnosis: ____________

☐ Scarlet Fever
☐ Seizures
☐ Stroke/TIA
☐ Tuberculosis
☐ Vision Problem
☐ Other: ____________

EMERGENCY CONTACT

In case of emergency, please list anyone who you would like us to contact and with whom you will allow us to share information.

Name: ____________ Number: ____________ Relationship: ____________

PRIVACY POLICY

I acknowledge receipt of the notice of Privacy Practices from our company. The notice of Privacy Practices provides information about how we may use and disclose your protected health information.

Today's Date: ____________________ Patient Initials: ☐

END OF INTAKE

FOR STAFF USE ONLY

STOP

IMPORTANT MEDICAL CONSIDERATIONS FOR HEARING AID FITTING- COMPLETED BY PROVIDER

☐ Yes ☐ No Acute or chronic dizziness
☐ Yes ☐ No Pain or discomfort in the ear
☐ Yes ☐ No History of sudden or rapidly progressive hearing loss within the previous 90 days
☐ Yes ☐ No Unilateral hearing loss of sudden or recent onset withing the previous 90 days
☐ Yes ☐ No History of active drainage from the ear within the previous 90 days
☐ Yes ☐ No Visible congenital or traumatic deformity of the ear
☐ Yes ☐ No Visible evidence of significant cerumen accumulation or a foreign body in the ear canal
☐ Yes ☐ No Audiometric air-bone gaps equal to or greater than 15 db at 500, 1K, and 2K Hz

I have reviewed the Confidential Case History and Information Statements with the patient.

Licensed Staff Signature: ______________________________ Date: ____________________

Title: Hearing Care Provider

License #: HADS000859