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Moline, IL 61265
(309) 764-3065

2882 AAA Court
Bettendorf, IA 52722
(563) 888-5482

2728 Asbury Rd., Suite 100
Dubuque, IA 52001
(563) 582-9916

New Patient Information Packet

Thank you for scheduling your appointment with our office. We look forward to meeting you. We have reserved this time especially for you. If you need to reschedule or cancel, please let us know as soon as possible as we have a waiting list of patients that would like to come in sooner.

Appointment Date:________________________ Appointment Time:____________________________

Please take a moment and complete the enclosed papers and bring them with you for your appointment.

IMPORTANT – Bring the person you communicate with the most on a daily basis- spouse, family member or friend- with you to your appointment.

Best practices and our specialists find it beneficial to get an objective assessment of your hearing issues and difficulties. **Our specialists require a familiar voice during the three part evaluation to assess how you hear sound, your ability to hear voices in noise, and your ability to respond in real life situations.** Most people bring the person they spend the most time with in their life.

We look forward to seeing you!

The Audibel Hearing Solutions team

Patient Information Form

Name:______________________________ Sex: M____ F____ Birth date:______________

Address:______________________ Apt #:______ City:____________ State:______ Zip:_______

Phone:__________________________ Secondary Phone:___________________________

Marital Status: Married_______ Single_______ Widowed_______ Guest Name:______________

Email Address____

How did you hear about us?____

If you were referred to us, who should we thank?___________________________

Occupation:________________________ ☐ Past ☐ Present

Name of Family Physician_________________________ Phone #_____________________

Address_____________________________ City:______________ State:______ Zip:_______

May we contact your physician with these results? Y____ N____ Signature_______________

Emergency Contact Name_________________________ Phone________________________

Primary Insurance_______________________ Secondary Insurance____________________

Name of Insured_______________________ Relation to Patient____________ DOB________

Hearing History Form

What is the reason for today's visit?_______________________________________

Have you ever had your hearing tested before? Y____ N____

If Yes: When?_________________ Where?_______________________________________

Was a hearing loss noted at that time? Y____ N____

Recommendations?____

Does anyone in your family have a hearing loss? Y____ N____ Who?_______________

Have you ever been exposed to loud sound? Y____ N____ Where?_____________________

Do you have ringing in your ears/head (tinnitus)? Y____ N____

Do you have fullness in your ears? Y____ N____

Does earwax ever cause a problem for you? Y____ N____

Which ear do you think hears better? Right_____ Left_____

Do you currently wear hearing aids? Y____ N____

Date of Purchase:__________ Place of purchase:___________________________________

Problems/difficulties with your current hearing aids:_____________________________

____

Medical History

Have you ever had ear surgery? Y____ N____

If yes, why?_______________________________ When?___________________________

Which ear?______________ Result?____

Have you ever had trauma to the head? Y_____ N_____

Do you have sinus or allergy problems? Y_____ N_____

Have you consulted a physician re: your hearing problem? Y_____ N_____

Have you had or currently have any of the following:

High blood pressure	☐	Mumps	☐
Arthritis	☐	Stroke	☐
Cancer	☐	Kidney Disease	☐
Meningitis	☐	Measles	☐
Heart Disease	☐	AIDS/HIV	☐
Diabetes	☐		

Please list any medications/blood thinners you are taking, including over-the-counter (use the back of the page if needed): ____

____

In what situations would you like to hear better?____

____

What is it about NOW, that has encouraged you to make a positive decision about your hearing?

____

If you are fortunate enough to be helped, are you prepared to continue on a program for better hearing which may include the use of hearing aids? Y_____ N_____

Are you aware that if you have an untreated hearing loss, you are up to five times more likely to develop dementia? Y_____ N_____

Are you aware that if you have an untreated hearing loss, you are three times more likely to suffer a fall? Y_____ N_____

FOR OFFICE USE ONLY!

FDA Questions

Otoscopic Exam: Right Ear______________________________Left Ear______________________________

Visible congenital or traumatic deformity of the ear? Y_____ N_____

Visible evidence of significant cerumen accumulation or a foreign body in the ear canal? Y_____ N_____

Any history of, or active drainage from, the ear within the previous 90 days? Y_____ N_____

Any history of sudden or rapidly progressive hearing loss within the previous 90 days? Y_____ N_____

Have you experienced any acute or chronic dizziness? Y_____ N_____

Is there a unilateral hearing loss of sudden or recent onset within the previous 90 days? Y_____ N_____

Have you experienced any pain or discomfort? Y_____ N_____

Audiometric air-bone gap equal to or greater than 15dB at 500Hz, 1000Hz, and 2000Hz? Y_____ N_____

Hearing Care Professional______________________________License #______________________________

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