Case History

HEARCARE, INC. & ASSOCIATES

Date: _____ / _____ / _____

Name: _____ DOB: _____ / _____ / _____ Age: _____ **Male / Female**

Address / City / State / Zip: _____

Home Phone: (_____) _____ - _____ Work Phone: (_____) _____ - _____, Ext. _____

Person Responsible for Payment: _____

How did you hear about HearCare? _____

Doctor / Phone Number: _____, (_____) _____ - _____

Insurance: _____

Phone Number: (_____) _____ - _____ Group Number: _____

Insured's Name: _____ DOB: _____ / _____ / _____

SSN or ID Number: _____ Spoke With: _____

Benefits: _____

_____

Services Needed: _____

_____

HEARING HISTORY

Have you ever had your hearing tested before? If so, when? **Yes / No** Date: _____ / _____ / _____

When did you first notice you had a hearing problem? _____

What do you think caused your hearing loss? _____

Had your hearing loss gradually progressed or did it become worse suddenly? _____

Have you ever experienced any of the following? (Check all that apply):

_____ Ringing	_____ Excess Ear Wax	_____ Meningitis
_____ Dizziness	_____ Ear Surgery	_____ Diabetes
_____ Nausea	_____ Difficulty Understanding	_____ Sinus Problems
_____ Allergies	_____ Exposure to Loud Noise	_____ Guns
_____ Earaches	_____ Work-Related Noise Exposure	_____ Frequent Colds
_____ Loud Music	_____Sudden Hearing Loss	_____ Ear Infections

_____ Speech / Language Development Problems

Treatment(s) for the Above: _____

_____

Do other members of your family have a hearing problem? _____

Who is your Ear/Nose/Throat doctor? _____

If Patient is a Child: Are they developing speech / language normally? _____

Are they doing most things as soon as others their age? _____

Are they experiencing difficulty in school? If so, what subject(s) / school / teacher(s)? **Yes / No** _____

_____

MEDICAL HISTORY

Status of Health: _____

Surgeries: _____

Ear Infections: _____ Ear Surgeries: _____

List of Medications: _____

_____