WEST MONROE HEARING HEALTHCARE CENTER

105 McMillan Road, West Monroe, LA 71291
318-605-3321

Welcome to West Monroe Hearing Healthcare Center! We want to provide excellent hearing healthcare services to you. Please tell us a little about yourself by completing as much information as possible.

How did you hear about us? ___Physician Referral ___Newspaper ___Website ___ Direct Mail ___Word of mouth

PERSONAL INFORMATION:

PATIENT'S NAME: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

HOME PHONE: _____ CELL PHONE: _____

BIRTHDATE: _____ MALE: _____ FEMALE: _____MARITAL STATUS: _____

PRIMARY CARE PHYSICIAN & PHONE NUMBER: _____

NAME & PHONE # OF NEAREST RELATIVE: _____

EMAIL ADDRESS: _____SS#_____

MAY WE CONTACT YOU BY: MAIL _____ HOME PHONE_____ CELL _____ EMAIL _____
(Please check all that apply.)

MEDICAL:

Do you have pain/discomfort in your ear? Yes_____ No _____ L _____ R _____ Both _____
Do you have any drainage in your ear? Yes_____ No _____ L _____ R _____ Both _____
Do you have a history of ear infections: Yes_____ No _____ L _____ R _____ Both _____
Do you have ringing or other noises in your ear? Yes_____ No _____ L _____ R _____ Both _____
Is it constant or intermittent? (Please circle one)
Do you have dizziness or vertigo? Yes _____ No _____
Have you ever had ear surgery? Yes _____ No _____ L _____ R _____ Both _____
Sudden or rapid loss of hearing in the past 90 days? Yes _____ No _____ L _____ R _____
Have you seen a physician regarding any of the above? _____

Please check any of the following that you currently have or have had in the past:
___Alzheimer's/Dementia ___Anxiety/Depression ___Arthritis ___Asthma ___Bell's Palsy
___Blood Thinners ___Chemo ___Diabetes ___Head Injury ___Heart Condition ___Hepatitis
___High Blood Pressure ___HIV ___Malaria ___Measles ___Meniere's ___Meningitis
___Multiple Sclerosis ___Mumps ___Parkinson's ___Scarlet Fever ___Sinusitis ___Stroke/TIA
___Tuberculosis ___Visual Trouble-Loss Sight

Do you take any medication: Yes _____ No _____ Please list:

_____
_____
_____

HEARING:

Do you think you have a hearing loss? Yes _____ No _____

Is there a family history of hearing loss? Yes _____ No _____
If Yes, who? _____

Have you had noise exposure? Yes _____ No _____
If Yes, from work/military/hobbies, etc., please specify: _____

Have you had your hearing tested before? Yes _____ No _____ When _____
Results: _____

Do you currently use a hearing device? Yes _____ No _____
If Yes, how well does it meet your needs? _____

Do You:

___Yes ___Sometimes ___No Hear but don't understand?
___Yes ___Sometimes ___No Have trouble understanding speakers at a distance?
___Yes ___Sometimes ___No Have difficulty understanding on the phone?
___Yes ___Sometimes ___No Have difficulty understanding speech in noisy situations?
___Yes ___Sometimes ___No Have difficulty understanding the TV?
___Yes ___Sometimes ___No Do others tell you the TV is too loud?
___Yes ___Sometimes ___No Have difficulty understanding speech in the car?
___Yes ___Sometimes ___No Feel your ability to hear limits your work, personal and/or social life?

If amplification is recommended, please rank the following in order of importance from 1 (highest) – 3 (lowest):

_____ Best Possible Hearing _____ Price _____Cosmetic

What is the primary reason for your visit? _____

WEST MONROE HEARING HEALTHCARE CENTER
105 McMillan Road
West Monroe, LA 71291
318-605-3321

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of West Monroe Hearing Services, LLC, Notice of Privacy Practices and have been informed that I can request a copy of the Notice at any time either by hard copy or by email. I have read and understand the Notice and I have had an opportunity to ask questions about the use and disclosure of my health information, and other concerns regarding my health information.

_____ _____

Signature of Patient (or Personal Representative) Date

_____

Printed Name of Patient (or Personal Representative)