WEST MONROE HEARING HEALTHCARE CENTER

105 McMillan Road, West Monroe, LA 71291
318-605-3321
www.wmhhc.com

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? (Circle) Radio Show Newspaper Website Direct Mail Word of mouth Physician

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: ______________________________

MAY WE CONTACT YOU BY: ______ MAIL ______ PHONE ______ CELL ______ TEXT ______ 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? ______________________________

HEARING HEALTH HISTORY:

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: ______________________________

Which ear do think is your better ear? Right_________ Left________ Not sure__________

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

Do You:

Hear but don't understand?	__Yes __Sometimes __No
Have trouble understanding someone speaking at a distance?	__Yes __Sometimes __No
Have difficulty understanding on the phone?	__Yes __Sometimes __No
Have difficulty understanding speech in a noisy situation?	__Yes __Sometimes __No
Have difficulty understand the T.V.?	__Yes __Sometimes __No
Do others tell you the T.V. is too loud?	__Yes __Sometimes __No
Have difficulty understanding speech in the car?	__Yes __Sometimes __No
Feel your hearing is affecting your work, personal and/or social life?	__Yes __Sometimes __No

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

______ Best Possible Hearing ______ Price ______Cosmetic

What is your primary goal during our visit today?

____

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: ____________________________ Print Name: _________________________

Date: ________________________________