



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

How did you hear about us? (Circle) Radio Show Online 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: _____

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 _____
 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 the 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: _____