Patient Demographic Form

Physician Hearing Centers
640 East Aurora Rd. #C
Macedonia, OH 44056

Name: _____ Date of Birth: _____

Preferred Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Please check all that apply: ☐ Male ☐ Female ☐ Employed ☐ Retired ☐ Married ☐ Single ☐ Widowed

Companion/Contact Name: _____ Phone: _____

May we discuss your care with this person? ☐ **YES** ☐ **NO**

Primary Doctor: _____ Phone: _____

Referring Doctor: _____ Phone: _____

Would you like your results sent to your doctor? ☐ **YES** ☐ **NO**

How did you hear about us? Doctor: _____ (Name) Friend: _____ (Name)

Newspaper: _____ (Name of Paper) Mailing: _____ (Type) Other: _____ (Yellow Pages, Internet, Signage, Outreach)

Health History **Please circle all that apply:**					
Ear Pain/Fullness **R L**	Ear Surgery **R L**	Ringing **R L**	Ear Infections	Cardiovascular Issues	Diabetes
Balance Issues/Dizziness	Head Injury	Memory Issues	Stroke	Chemotherapy/Radiation	Diuretics
Family History					
Hearing Loss:	Mother	Father	Sibling	Grandmother	Grandfather
Lifestyle					
Loud Noise Exposure:	Work	Military	Firearms	Heavy Machinery	Other
Most Recent Hearing Test:	Never	5+ years	2-5 years	1-2 years	Less than 1 year ago
Current Hearing Aid User:	Yes	No	If yes, when did you purchase your aids?		
Hearing Concerns					
Which of the following situations are most challenging for you?					
1 on 1 conversations	Meetings	In the car	TV	At a restaurant	Kids' voices
Group conversations	Religious Services	On the phone	Music	Women's voices	Outdoors
Other:					