CONCIERGE AUDIOLOGY
LAS VEGAS

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PATIENT INTAKE INFORMATION

Today's Date: _____

Last Name: _____ **First Name**:_____
Middle Name:_____ **Date of Birth**: _____

Home address: _____
Work address (optional/for appointments): _____
Primary location for appointments: _____
Home phone#: _____ **Cell phone#**: _____
Office phone#: _____
Name of Guardian/Caretaker and contact information:_____
_____
Preferred mode of communication for appointments (circle one):
home phone cellphone office guardian
Email Address:_____
Permission to text/email/leave voicemails pertaining to appointments, etc (circle): YES/NO
Occupation (current/former):_____

Name of PCP and phone #:_____
Referral Source/Name:_____

If you have experienced the following symptoms, please check all that apply:

- ☐ Ear pain
- ☐ Dizziness or vertigo
- ☐ Sudden hearing loss within 90 days
- ☐ Drainage from ear(s) within 90 days
- ☐ Ear surgery
- ☐ Head trauma
- ☐ Diabetes
- ☐ Pacemaker use
- ☐ History of noise exposure (occupational or recreational)
- ☐ High blood pressure
- ☐ Vision difficulty
- ☐ Rheumatoid arthritis
- ☐ Autoimmune disease
- ☐ Cardiovascular disease
- ☐ Dementia
- ☐ Allergies to acrylic, latex, or vinyl
- ☐ Seasonal allergies
- ☐ Family history of hearing loss
- ☐ PE tubes (past or currently)

- ☐ History of chronic ear infections
- ☐ Radiation treatment of head/neck
- ☐ Eardrum perforation
- ☐ Cholesteatoma
- ☐ Exostoses
- ☐ bleeding/blood clotting disorders
- ☐ Use anti-coagulant medication
- ☐ Compromised immune system (HIV/Lupus/chemotherapy within last 6 months)
- ☐ Tinnitus/Ringing in ear(s)
- ☐ Other: _____
- ☐ Ear surgery (describe): _____

If you experience tinnitus, check all that apply:

- ☐ Present in both ears
- ☐ Present in one ear (circle R or L)
- ☐ periodic/occasional
- ☐ Constant
- ☐ Sounds like a drum/heartbeat

From a scale from 1 (not much at all) to 5 (extremely), how bothersome/disruptive is your tinnitus?: _____

Please list medications: _____

Have you had your hearing tested before? _____
What was the outcome? _____
Which ear is the better ear or not sure? _____
Have you used hearing aids or use them currently? _____
What do you like/dislike about your current hearing aids? _____
Where do you experience difficulty hearing (places and situations):

- ☐ Noisy places like restaurants
- ☐ On the phone
- ☐ Watching TV
- ☐ In the car
- ☐ Place of worship
- ☐ Listening to music
- ☐ Specific voices (i.e. wife or grandkids): _____
- ☐ Other (specify): _____

Please describe how your hearing loss has affected you:

_____
Please list your goals, concerns, or questions here: _____
Are you interested in listening to audio from a device such as a cellphone, tablet, or TV through hearing aids? Which devices would you be interested in?

- ☐ Iphone
- ☐ Ipad
- ☐ TV
- ☐ Android cellphone
- ☐ Android tablet
- ☐ Computer
- ☐ Other: _____