HEARING & BALANCE SPECIALIST
OF ILLINOIS

21124 Washington Parkway Frankfort, IL 60423 Phone: (815) 239-0673

Patient Information Form

Name:	Birth Date:
Street:	
City:	Zip Code:
Email:	
Home Phone:	Cell Phone:
Occupation:	Employer:

Preferred method of contact: Cell Phone Home Phone Email

Primary Physician:	
Phone Number:	Fax Number:
Street:	
City:	Zip Code:

How did you hear about us? _____

Primary Insurance Information

Insurance Company:	
Subscriber Name:	Subscriber Birth Date:
Identification Number:	
Group Number:	

Secondary Insurance Information

Insurance Company:	
Subscriber Name:	Subscriber Birth Date:
Identification Number:	
Group Number:	

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Case History

1. What is your primary concern? _____
2. What do you think caused your hearing problem? _____
3. If you have a hearing loss, how long have you noticed it? _____
4. Which is your worse ear? Left: _____ Right: _____ No difference: _____
5. What environments are more difficult to hear in? _____

Hearing History

1. Have you had your hearing tested before?	Yes_____	No_____
2. Any drainage from the ear(s) within the past 90 days?	Yes_____	No_____
3. Have you experienced any dizziness, balance problems, or falls?	Yes_____	No_____
4. Have you had any pain/discomfort in your ear(s)?	Yes_____	No_____
5. Do you have any noises (ringing, buzzing, etc.) in your ears?	Yes_____	No_____
6. Have you received medical/surgical treatment for hearing loss?	Yes_____	No_____
7. Have you ever worn or currently wear hearing aids?	Yes_____	No_____
If so, for how long? _____		
8. Have you ever been exposed to loud noise?	Yes_____	No_____
9. Is there a history of hearing loss in your immediate family?	Yes_____	No_____

Medical History (Check any that apply)

Infectious disease _____	High Blood Pressure _____	Diabetes _____
Heart Problems _____	Head Injury _____	Strokes _____
Headaches _____	Neck/Back Issues _____	Cancer _____

Other (Please explain): _____

Current Medications: _____

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Today's Appointment

I have been thinking I might need hearing aids. Yes _____ No_____

I am ready to wear hearing aids if they are recommended. Yes _____ No_____

What are your goals for today's appointment? _____

_____

Other comments and questions:

_____ _____

Patient Signature Date Parent/Guardian Date

_____

Doctor Signature Date

Doctor Notes / Follow Up: