West Tennessee
Hearing Aid Center

Name _____ Date _____ / _____ / _____
Last First Middle Initial

◯ Married ◯ Single ◯ Widow(er) Observing Party _____
Name Relationship

Permanent Address _____
Street City State Zip

Phone (_____) _____ - _____ ◯ Home ◯ Cell ◯ Work

May we send appointment reminders by text message? ◯ Yes ◯ No

Date of Birth _____ / _____ / _____ Age _____ E-Mail Address: _____

Spouse/Nearest Relative _____
Name Relationship

Phone (_____) _____ - _____

Family Physician _____
Name City State

Referral Source (check one):

◯ Doctor Referral ◯ Patient Referral / Friend / Family _____ ◯ Walk-in

◯ Mail ◯ TV ◯ Internet ◯ Newspaper (which one) _____

Medical History

Are you allergic to plastic?..... ◯ Yes ◯ No Are you an insulin dependent diabetic?..... ◯ Yes ◯ No

Do you have arthritis?..... ◯ Yes ◯ No Are you currently taking any antibiotics?..... ◯ Yes ◯ No

Have you received any medical or surgical treatment for a hearing loss?..... ◯ Yes ◯ No

If yes, when? _____ Physician/ENT: _____

Additional information about treatment: _____

Hearing Instrument Experience

Have you ever worn hearing instruments?..... ◯ Yes ◯ No ◯ Left ◯ Right ◯ Both

Are you wearing hearing instruments now?..... ◯ Yes ◯ No ◯ Left ◯ Right ◯ Both

Year Purchased: _____

Please check below if you are experiencing any of the following problems with your hearing instrument(s):

- ☐ Some sounds are too loud
- ☐ Everything sounds tinny
- ☐ The hearing instrument(s) whistle(s)
- ☐ Wind noise bothers me
- ☐ My ears feel plugged
- ☐ Telephone use is difficult
- ☐ Understanding when two or more people are talking
- ☐ Knowing from which direction sounds are coming
- ☐ The hearing instruments(s) is (are) uncomfortable in my ears
- ☐ My voice sounds hollow and unnatural
- ☐ Don't hear as well as when originally purchased
- ☐ Other: _____

Patient Signature: _____