South Shore Hearing Center

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www.sshc.com

ADULT REGISTRATION

Patient Name:_____Date of Birth: _____

Reason for today's visit: _____

Have you ever had a hearing test? If so, where and when? _____

Please check all that apply:

Hearing Loss ……	□ Right Ear	□ Left Ear	□ Both Ears	
Tinnitus (Noise) In Ears……	□ Right ear	□ Left ear	□ Both Ears	
Ear Pain……	□ Right Ear	□ Left Ear	□ Both Ears	
Ear Drainage ……	□ Right Ear	□ Left Ear	□ Both Ears	
Chronic Wax Build-up……	□ Right Ear	□ Left Ear	□ Both Ears	
Chronic Ear Infections In Past……..	□ Right Ear	□ Left Ear	□ Both Ears	
Perforated Ear Drum……..	□ Right Ear	□ Left Ear	□ Both Ears	
Ear Surgery……..	□ Right Ear	□ Left Ear	□ Both Ears	
Noise Exposure……..	□ Gunfire	□ Machinery	□ Loud Music	□ Other:_____
Did you serve in the military?.....	□ No	□ Yes		
Are you a smoker?.....	□ No	□ Yes	□ I quit, date: _____	
Family members with hearing loss……..	□ No	□ Yes: _____		
Chemotherapy in the past……	□ No	□ Yes:_____		

Dizziness…… □ No □ Yes

Please describe your dizziness: □ Spinning □ Off-Balance □ Lightheadedness □ Motion provoked

Is your dizziness accompanied by: □ Vomiting □ Nausea □ Ear Noises

Have you had two or more falls in the past 12 months OR 1 fall with an injury? □ No □ Yes

Have you ever had vestibular testing or rehabilitation? □ No □ Yes_____

Do you currently wear a hearing aid/s? □ No □ Right Ear □ Left Ear □ Both Ears

Where did you purchase your hearing aid/s? _____

Is it under manufacturer warranty? _____

Please list medical problems, conditions or surgeries we should be aware of. (Diabetes, Hypertension, Arthritis, HIV, Cancer, Genetic Disorders, etc)

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_____

_____

Current Medications / Dosage: Always follow your prescribing physicians directions in relation to the referenced medications.

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