

## HEARING EVALUATION APPOINTMENT FORM

Patient Information			
First Name	Last Name	Date of Birth	Gender
Street Address	City	State	Zip Code
Phone Number	Email Address	Contact Preference	

Primary Care Physician		
Full Name/Practice	Address	Phone Number

Hearing Related Questions	
What is the reason for your hearing test?	
Do you experience ringing or buzzing (Tinnitus)?	
Do you have a history of ear infections?	
Have you ever had a head injury or trauma that affected your hearing?	
Have you been exposed to loud noises at work or during other activities?	
Do you have a family history of hearing loss?	
Have you noticed any recent changes in your hearing?	
Do you often ask people to repeat themselves?	
Do you have difficulty hearing in crowds?	
Do you often turn up the TV volume or on other devices?	

**Appointment Date:**

**Appointment Time:**