CLEARCHOICE HEARING AND BALANCE

Referral:________________________

# Patient Information

Date:_______________________________________________Name:______________________________________________________________

Preferred Name: ___________________________________DOB:___________________________________ Age:______________________

Address: ___________________________________________City/State/Zip_______________________________________________________

Home Phone: _______________________________________Cell Phone:_________________________________________________________

Work Phone: _______________________________________ Email address: _____________________________________________________

Occupation: _______________________________________ Contact Person: ____________________________________________________

Phone #____________________________________________ Primary Care Doctor: _______________________________________________

Address____________________________________________ Phone # __________________________________________________________

Primary Insurance/ID# _______________________________________Secondary Insurance/ ID # _______________________________

**PLEASE HAVE A MEDICATION LIST**

Do you think/know you have a hearing loss? YES / NO

Have you ever had your hearing tested? YES / NO When?__________________________________________

Do you have tinnitus/ringing in your ears? YES / NO

Are you a veteran? YES / NO

ANY surgery/trauma to head or neck? YES / NO Describe ________________________________________

Has he/she been exposed to loud noises? YES / NO Describe ________________________________________

Do you experience any acute/chronic dizziness? YES / NO

Family history of hearing loss? YES / NO

Do you or have you ever worn hearing aids? YES / NO

Do you take any aspirin or blood thinners? YES / NO

Greece
103 Canal Landing Blvd Ste. 3
Rochester, NY 14626
P: (585)723-3440
F: (585)735-4632

Brighton
1065 Senator Keating Blvd Ste 210
Rochester, NY 14618
P: (585)342-4327
F:(585)735-4632

**PLEASE CHECK ALL THAT APPLY**

| | | |
|---|---|---|
| _____Stroke | _____Arthritis | _______Shingles |
| _____Memory loss | ______Ear infections | _______ Radiation |
| _____Neuropathy | _____Vision Problems | ________Cancer |
| _____Depression/Anxiety | _____High blood pressure | ________Chemotherapy |
| _____Head Injury | _____Diabetes Type (1)___ or (2)___ | ______ Heart condition |
| _____Epilepsy/ Seizures | ______Migraine | ______Tobacco Use |

Please list any medical conditions or history I should be aware of: ____________________________________________________________

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