Blackstone Valley HEARING CENTERS

1044 Smithfield Avenue
Lincoln, RI 02865
401-725-5798
www.blackstonevalleyhearing.com

Hearing Health Report

Personal Information

Name _____ Male / Female

Address _____City _____ State_____ Zip _____

Home Phone (____) _____ Cell Phone (_____) _____

Date of Birth _____ Occupation _____

Marital Status _____ Email address _____

Accompanying Party or Companion_____ Relationship _____

Family Physician _____ Phone Number _____

Medical and Hearing Health History

Referred by _____

Reason for visit _____

Do you have any allergies? ____ YES ____ NO

Are you diabetic? ____ YES ____ NO

Are you taking blood thinners? ____ YES ____ NO

Medical conditions? _____

_____

Do you have ringing or other noises in your ears? ____ YES ____ NO

Have you had a hearing test before? ____ YES ____ NO

If yes, when? _____

Have you had ear surgery? _____ YES ____ NO

Are you a current hearing aid wearer? _____ YES ____ NO

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Health History, continued

Is there a family history of hearing loss?	_____ YES ____ NO
Do you have pain in your ears?	_____ YES _____ NO
Do you have drainage in your ears?	_____ YES _____ NO
Was the change in your hearing sudden?	_____ YES _____ NO
Do you have earwax removed regularly?	_____ YES _____ NO
Have you been exposed to loud noises?	_____ YES _____ NO
Were you in the military?	_____ YES _____ NO

Financial Policy

Payment is expected at time of service.
Returned checks will incur a $35 fee.
Accounts with non-payment may be referred to an outside collections agency after 90 days.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received a copy of the Notice of Privacy Practices.

Print Name _____

Signature _____ Date _____

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Hearing Questionnaire

Name: _____

1. Do you have trouble with your hearing? YES / NO / SOMETIMES

2. Do you have have difficulty understanding when people speak softly?
YES / NO / SOMETIMES

3. Do you have difficulty hearing someone speak from another room?
YES / NO / SOMETIMES

4. Do you have difficulty hearing someone who is not facing you?
YES / NO / SOMETIMES

5. Do you have difficulty hearing in noise (restaurants)? YES / NO / SOMETIMES

6. Do people tell you that the TV is too loud?
YES / NO / SOMETIMES

7. Do you have difficulty catching the words in a movie? YES/ NO/ SOMETIMES

8. Do you have difficulty hearing on the phone? YES / NO / SOMETIMES

9. Do you have trouble making out the words in songs? YES / NO / SOMETIMES

10. Do you have difficulty hearing in a group setting? YES / NO / SOMETIMES

11. Do you have a history of noise exposure? YES / NO

12. Anything else we should know? _____