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

**Appointment Date:**

**Appointment Time:**