

CONFIDENTIAL PATIENT HISTORY

MEDICAL HISTORY:

- Yes No Have you seen a doctor in the past six months? (Dr. _____)
- Yes No Have you seen a doctor specializing in diseases of the ear?
If yes, give date ____ / ____ / _____
- Yes No Have you ever had your hearing tested?
If yes, give date ____ / ____ / _____ by whom _____
- Yes No Have you ever had any type of ear surgery?
If yes, type of surgery _____ (Dr. _____)
- Yes No Do you take any medications?
If yes, for what condition? _____
- Yes No Do you have any other medical conditions?
If yes, explain _____
- Yes No Have you ever seen a doctor for wax removal?
- Yes No Are you hypertensive?
- Yes No Are you anxious?
- Yes No Have a heart condition?

ABOUT YOUR EARS: Do you have any of these symptoms?

- Yes No Deformity of the ear
- Yes No Drainage from the ear
- Yes No Sudden or rapid loss of hearing in the past 90 days
- Yes No Acute or chronic dizziness
- Yes No Ear infections
- Yes No Do you ever have pain in your ears?
- Yes No Ever experience tinnitus?
If yes, select the following that apply
Tinnitus is in the: right ear left ear both ears
Onset has been: progressive sudden
Tinnitus is: constant intermittent
Tinnitus is described as: ring buzz other: _____
How long have you had tinnitus? ____ Years ____ Months ____ Days

ABOUT YOUR HEARING: Do you experience difficulty with the following?

- Yes No Understanding conversation
- Yes No Hearing in a crowd
- Yes No Hearing on the telephone
- Yes No Hearing the television

How long have you had a hearing problem? _____

- Yes No Does anyone else in your family have a hearing problem? What relationship? _____
- Yes No Do you now or have you ever worn a hearing aid?
If yes, what help are you seeking? _____

Consent for Treatment

I voluntarily give my permission to the health care providers of Sharp Hearing and such assistants and other health care providers as they may deem necessary to provide services to me. I understand by signing this form, I am authorizing them to treat me for as long as I seek care from Sharp Hearing, or until I withdraw my consent in writing.

I understand that all information shared with the clinicians at Sharp Hearing is confidential and no Information will be released without my consent. I further understand that there are specific and limited Exceptions to this confidentiality which include the following:

- A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.
- B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child, and to inform the proper authorities.
- C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that Sharp Hearing services are provided by a range of hearing health professionals, some of whom may be in training. All professionals-in-training are supervised by licensed staff.

Treatment of minors: I, the undersigned, understand that a minor child (17 and under) must have my consent to be treated. I understand that consent for treatment does not alter the legal requirements for confidentiality.

If I have any questions regarding this consent form or about the services offered at Sharp Hearing, I may discuss them with my clinician. I have read and understand the above. I consent to participate in the evaluation and treatment offered to me by Sharp Hearing. I understand that I may stop treatment at any time.

Name

Relationship/Facility

Please list above any individuals or medical facilities you give permission to have your medical information released to/from.

Signature: _____

Date: ____ / ____ / _____