

Hearing Healthcare Center, Inc.

Angela K. Graves, AuD
Doctor of Clinical Audiology

3101 N. Green River Road, Ste. 510
Evansville, IN 47715
812.303.4300

Date: _____

Hello and welcome!

What is your hearing aid experience?

- I use hearing aids regularly.
- I have hearing aids but rarely use them.
- I have never used hearing aids.
- I had my hearing tested at another office but never tried wearing hearing aids.
- I once tried hearing aids but with no success.

Name: _____ Birthdate: _____

Sex: Male Female Marital status: Single Married (spouse: _____) Widowed

Primary address: _____
Street City State ZIP

Home phone: _____ Cell phone: _____ Work phone: _____

Email address: _____

Primary physician: _____ Employer: _____

Emergency contact: _____
Name Relationship Phone

1. Have you sought help for your hearing within the past 12 months? Yes No
2. From which ear do you hear better? Right Left Both the same
3. Does your hearing change from time to time? Yes No
4. Have you been exposed to loud noises recently or in the past? Yes No
5. Are you dizzy at times, or do you have balance problems? Yes No

Do you have:

- Ear pain? Right Left
- Ear drainage? Right Left
- Fullness in the ears? Right Left
- Ringing in the ears? Right Left

Please check all that apply:

- High blood pressure Heart attack Pacemaker Arthritis
- Visual problems Head injury Aspirin therapy Diabetes
- Stroke Other medical conditions: _____
- Ear infections or surgery (include dates): _____



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PH: (812) 303-4300
FX: (812) 303-4308

www.HearBetterEvansville.com