aim hearing AND AUDIOLOGY
Emil Frymark & Shannon Frymark, Doctors of Audiology
529 College Road, Suite B, Greensboro, NC 27410 • (336) 294-9617

PATIENT INFORMATION

PATIENT NAME _____

DATE OF BIRTH _____ PERFERRED NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ CELL PHONE _____

WORK PHONE _____ EMAIL _____

PREFERRED METHOD OF CONTACT ○ HOME # ○ WORK # ○ CELL # ○ TEXT ○ EMAIL

OCCUPATION (PAST/PRESENT) _____

MARITAL STATUS _____ SPOUSE'S NAME _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

NAME OF RELATIVE/FRIEND WITH YOU TODAY _____

HOW DID YOU HEAR ABOUT US?

○ MAIL ○ FACEBOOK ○ HEALTH FAIR ○ INTERNET
○ INSURANCE ○ WEBSITE ○ YELLOW PAGES ○ NEWSPAPER AD
○ FRIEND ○ PHYSICIAN
○ OTHER/EXPLANATION _____

PRIMARY CARE PHYSICIAN _____ ADDRESS/LOCATION _____

PRIMARY REASON FOR TODAY'S VISIT _____

INSURANCE INFORMATION

(fill out only if insured is different from patient)

PRIMARY INSURANCE NAME _____

INSURED'S NAME _____ INSURED DOB _____

PATIENT'S RELATION TO INSURED _____

POLICY # _____ GROUP # _____

SECONDARY INSURANCE NAME _____

INSURED'S NAME _____ INSURED DOB _____

PATIENT'S RELATION TO INSURED _____

POLICY # _____ GROUP # _____

PATIENT QUESTIONNAIRE

This information is kept confidential and is made a part of your permanent file. Thank you for placing your trust in us for all your hearing needs. Please complete and return to the front desk.

MEDICAL/AUDIOLOGIC HISTORY	YES	NO
▪ Will this be the first time you've had a hearing test?	☐	☐
If no, what year were you last tested? _____		
▪ Have you ever had ear surgery?	☐	☐
If yes, when? _____ which ear? _____ procedure? _____		
▪ Do you have ringing, roaring or any other noises in your ears?	☐	☐
If yes, is the tinnitus: constant intermittent pulsating		
Right Left Both		
▪ Did you have chronic ear infections as a child or adult?	☐	☐
Right Left Both		
▪ Do you have a family history of hearing loss?	☐	☐
▪ Have you been exposed to loud noises?	☐	☐
If yes, describe_____		
▪ Have you had any trauma to the head?	☐	☐
▪ Do your ear canals itch?	☐	☐
▪ Do you have sinus or allergy problems?	☐	☐
▪ Do you smoke?	☐	☐
▪ Has your vision changed recently?	☐	☐
▪ Does your hearing fluctuate?	☐	☐
▪ Do you have difficulty hearing friends, relatives or neighbors?	☐	☐
▪ Do you have a feeling of fullness in your ears?	☐	☐
▪ Do you have ear pain or discomfort?	☐	☐
▪ Do you experience acute or chronic dizziness?	☐	☐
▪ Did you have any active drainage within the past 90 days?	☐	☐
▪ In which ear do you hear better? circle: left right same		
▪ Why have you decided to have your hearing tested at this time?		
❒ I feel my hearing is poor and may need to be aided.		
❒ Family/friends have suggested I have my hearing checked.		
❒ Other reason/explain: _____		

MEDICAL HISTORY

Have you had or currently have any of the following:

High blood pressure	Heart disease	Stroke
Arthritis	Diabetes	Kidney disease
Cancer	Mumps	Measles
Meningitis	General anesthetic	Other
Thyroid Disease	Eyes: loss of vision/cataracts/glaucoma	

Please list any medications that you take (**If you have a list, let the receptionist make a copy**):

_____

_____

_____

_____

HEARING DIFFICULTY QUESTIONNAIRE

Indicate your ability to hear (Hearing Quality) in the following listening situations and rate the importance of that listening situation to you. Circle the appropriate number in columns two and three.

LISTENING SITUATION	HEARING QUALITY					IMPORTANCE TO YOU		
	POOR				NORMAL	NOT	SOMEWHAT	VERY
QUIET (one on one conversation)	1	2	3	4	5	1	2	3
TELEVISION	1	2	3	4	5	1	2	3
RESTAURANTS	1	2	3	4	5	1	2	3
CHURCH	1	2	3	4	5	1	2	3
MEETING/GROUPS	1	2	3	4	5	1	2	3
WORK PLACE	1	2	3	4	5	1	2	3
TELEPHONE	1	2	3	4	5	1	2	3
CAR	1	2	3	4	5	1	2	3
MALE VOICE	1	2	3	4	5	1	2	3
FEMALE VOICE	1	2	3	4	5	1	2	3
CHILD'S VOICE	1	2	3	4	5	1	2	3
OTHER (please explain below)	1	2	3	4	5	1	2	3

- What is your experience with hearing aids?
  ( ) I have never used hearing aids or visited a hearing healthcare professional.
  ( ) I have tried a hearing aids before.

	YES	NO
▪ If you wear hearing aids:	☐	☐
If yes, circle: left only right only both ears		
What year did you buy your hearing aids? _____		
Approximately how many hours a day do you wear them? _____		
Do you have any problems with your hearing aids?	☑	☑
If yes, explain: _____		

ASSESSMENT OF PRIORITIES RELATING TO HEARING CORRECTION

- Please rank the following in terms of their importance in a hearing aid.
  (1 through 5, with 1 being the most important)

  ( ) OVERALL SOUND QUALITY ( ) STYLE/APPEARANCE ( ) COST ( ) RELIABLILITY

  On a scale of 1-10, how motivated are you regarding a desire to do something about your hearing loss? (Please circle one)

0	1	2	3	4	5	6	7	8	9	10
	Not Motivated	Somewhat Motivated			Motivated			Very Motivated	Extremely Motivated	

Are there any other concerns that you wish to address?

_____

_____

_____

Thank You for helping us help you hear better!
Please return this form to the front desk.

_____

AUTHORIZATION TO USE AND DISCLOSURE OF HEALTH INFORMATION

I request and authorize Aim Hearing & Audiology Services to disclose my protected health information as described below. I understand that if the person/organization authorized to receive and use the information is not a health plan or health care provider, the disclosed information may no longer be protected by federal privacy regulations.

☐ I consent to Aim Hearing & Audiology Services releasing protected health as detailed below.

My protected health information may be used or disclosed to the following (ex: spouse, child, physicians name, etc.):

_____
_____
_____
_____

For the purpose of (ex: hearing exams, hearing records, etc.):

_____
_____
_____
_____

☐ I prohibit Aim Hearing & Audiology Services from using and disclosing medical information to any person or entity other than required by HIPAA regulations.

_____ _____

Signature of patient or personal representative Date