



Hearing Evaluation Profile

Patient Information

Legal Name _____ Preferred Name _____
 Address _____ City _____ State _____ Zip _____
 Home Phone _____ Alternate Phone _____ Email _____
 Age _____ Birth Date _____ Gender _____
 Family Physician _____ Occupation _____
 How did you hear about us? (Please check one) Word of Mouth Physician Mailing Yellow Pages
 Newspaper Mailing Other

Medical Information

Have you been examined by a doctor in the past six months? Yes No Doctor's Name _____
 Will this be your first hearing test? Yes No
 Have you had ear surgery? Yes No Type _____

Do you have any of the following?

Deformity of the ear? Yes No
 Sudden or rapid hearing loss in the past 90 days? Yes No
 Pain or discomfort in the ear? Yes No
 Acute or recurring dizziness? Yes No
 Ringing in the ears? Yes No
 Previous ear infections? Yes No
 Active drainage from the ear? Yes No

Have you ever found it necessary to have a doctor remove wax from your ears? Yes No
 In which ear is your hearing the worst? Left Right
 Are you taking any prescription medicine? Yes No Type _____
 Do you have any medical problems? Yes No Type _____

Hearing Instruments

Do you have a hearing instrument? Yes No
 Type of hearing instruments? (please check one) BTE (behind the ear) OTE (on the ear)
 ITC (in the canal) CIC (completely in the canal)
 Brand _____ How old? 1-2 yrs 3-4 yrs 5+ yrs

Medical Waiver

I have been advised by Golden State Hearing Aid Center and their licensed Hearing Aid Dispenser that the Food and Drug Administration has determined that my best interest would be served if I had a medical evaluation by a licensed physician (preferably by a physician who specializes in diseases of the ear) before purchasing a hearing instrument. I do wish to have a medical evaluation before purchasing an instrument. This test information shall be compiled for the purpose of making selections and adaptations of the hearing instrumentation. I am at least 18 years old.

Signature _____ Date _____

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MODESTO 200 W. Roseburg Ave., Suite B-2, Modesto, CA 95350 (209) 287-3272

FRESNO 3995 N. Fresno St., Suite 106, Fresno, CA 93726 (559) 354-0340