Foothills Hearing Centre Ltd.

Patient Information Chart

Name:		
Spouse:		
Address:		
City:	Province:	Postal Code:
Home Phone:	Birthdate:	Age:
Cell Phone:	Health Care #:	Email:
How did you hear about us?		

Medical History

Have you seen a doctor regarding your ears in the last 6 months?	Yes	No
Have you had your hearing tested before? If Yes when/why? ___________________________________	Yes	No
Have you ever had ear surgery? If Yes when/why? ___________________________________	Yes	No
Do you have any of the following:		
Ear drainage?	Yes	No
Sudden or rapid hearing loss in the past 90 days? If Yes in the Left or Right or Both ears? _____________________	Yes	No
Acute or recurring dizziness?	Yes	No
Do you have ear pain?	Yes	No
Have you had ear wax removed by a doctor? If Yes when? ___________________________________	Yes	No
Do you have ringing in your ear(s)? If Yes in the Left or Right or Both ears? _____________________	Yes	No
Do you feel your hearing is worst in one ear or the other or both?	Left	Right
How many years have you experienced hearing difficulty? ___________________		

Patient Signature: ___________________________ Date: _______________