

Adult Patient Intake - DEFAULT



Lifeline Audiology & Hearing Solutions
8553 Argyle Business Loop, Ste D
Jacksonville, FL 32244

Phone: (904) 479-5198
Fax: (904) 417-7012

Patient Information

1. Name:

2. Date of Birth:

3. Preferred Name:

4. Suffix: (ex. I, II, Jr., Sr.)

5. Title: (ex. Mr./Mrs./Ms.)

6. Sex:

- Male
- Female
- Not Specified

7. Social Security Number:

 - -

8. Family/Spouse/Guardian:

9. Marital Status:

- Single
- Married
- Divorced
- Partner
- Widowed
- Legally Separated
- Other

10. Employment Status: (required)

- Full-Time
- Part-Time
- Self Employed

- Not Employed
- Retired
- Active Military
- Disabled
- Full-Time Student
- Part-Time Student

Primary Address

11. Address Line #1: (required)

12. Address Line #2:

13. City: (required)

14. State / Province: (required)

15. Zip Code: (required)

Contact Information

16. Phone #1: (required)

 - -

17. Phone #2:

 - -

18. E-mail Address:

19. Reason for today's visit: (required)

20. Referred By: (required)

21. Have you had any of the following conditions? If YES, briefly explain.

- Kidney Disease
- Diabetes
- Cancer
- Hypertension
- Visual Problems
- Sinus Problems

Additional Comments:

22. List all medications you are currently taking:

Drug

Dosage

Frequency

Delivery Method

Comments

Add Medication

Medication List

No medications currently entered. Please use the form above to specify the applicable medications.

23. Have you ever experienced head trauma? If YES, briefly explain.

- Yes
- No

Additional Comments:

24. Have you ever had surgery on your ear(s), nose, or throat? If YES, briefly explain. (required)

- Yes
- No

Additional Comments:

25. Was your change in hearing SUDDEN or GRADUAL? (required)

- Sudden
- Gradual

26. When did you first notice your hearing problem?

27. Has your hearing become worse since you first noticed the problem? (required)

- Yes
- No

28. Do you hear better in one ear than the other? (required)

- Yes, Right ear is better
- Yes, Left ear is better
- No

29. Does your hearing REMAIN CONSTANT or FLUCTUATE? (required)

- Remains Constant
- Fluctuates

30. Have you experienced any ear pain? (required)

- Yes, Both Ears
- Yes, Left Ear Only
- Yes, Right Ear Only
- No

31. Have you experienced plugged ear(s)? (required)

- Yes, Both Ears
- Yes, Right Ear Only
- Yes, Left Ear Only
- No

32. Have you experienced any ringing/buzzing? (required)

- Yes, Both Ears
- Yes, Right Ear Only
- Yes, Left Ear Only
- No

Additional Comments:

33. Have you experienced any dizziness/vertigo? If YES, briefly explain. (required)

- Yes
- No

Additional Comments:

34. Have you ever been exposed to loud noise (work, recreation, Military service)? If Yes, briefly explain. (required)

- Yes
- No

Additional Comments:

35. Has anyone in your family experienced hearing loss? If YES, who? (required)

- Yes
- No

Additional Comments:

36. Which situations do you have difficulty hearing?

37. Have you had your hearing tested before? If Yes, briefly explain. (required)

- Yes
- No

Additional Comments:

38. Have you ever worn hearing instruments? If Yes, briefly describe. (required)

- Yes - Currently
- Yes - In The Past
- No

Additional Comments:

Self-Pay Cardholder Information

1. Cardholder Name, Address, Credit Card Number, Exp Date, CVV

Submit

Cancel