Patient Audiology Information Form
Audiology Innovations

Date:	WCB/DVA Number:
Name:	E-Mail:
Personal Health No:	Phone Number:
Seniors Subsidy ☐ YES ☐ NO	Date of Birth: Age:
Address:	

Tinnitus? (ringing in ears) ☐ YES ☐ NO _____

Dizziness? ☐ YES ☐ NO _____

History of noise exposure? ☐ YES ☐ NO _____

Ear surgery? ☐ YES ☐ NO _____

Do you wear hearing aids? ☐ YES ☐ NO _____

Other relevant information: (head injury/disease/MRI) _____

Where did you hear about our clinic? ☐ friend **(Please specify)** ☐ family **(Please specify)** ☐ Doctor ☐ Kerby ad ☐ website ☐ Deaf & Hear AB ☐ lecture ☐ other **(Please specify below)**

_____

Name of family Doctor: _____

Issues with hearing: ☐ in a group ☐ watching TV ☐ telephone ☐ asking people to repeat themselves ☐ other **(Please specify below)**

_____

Please list your top two things (ex. family, friends, spouse, colleagues, music, tv, telephone) you would like to hear better. 1._____ 2._____

Would you like to receive our e-mail newsletter to learn about proactive ways to keep your hearing healthy as well as up to date research in the field of auditory science (Please initial _____ if Yes).

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