Welcome to Carolina Ear Care

Please help us serve you better by taking a few minutes to provide the following information.

**** Please print clearly ****

Patient Information:

Name: ______________________________

Street Address: ______________________________

Apt # or 2nd line: ______________________________

City: ____________ Home Phone: (   ) ______________

State: ____________ Zip code: ____________

Date of Birth: ____________ Sex: ______ Male ______ Female

How did you hear about us? ______________________________

Emergency contact: Name ______________ Phone (   ) ________

May we leave messages regarding future appointments at your home phone number? Please check Yes or No: ______ Yes ______ No

Medical Information:

Have you ever had a hearing test? ______ If yes, did you have hearing loss? ______

____

Do you have trouble understanding people? ______________________________

Have you ever had ear surgery? ______________________________

Do you presently wear hearing aids? ______________________________

If YES, what brand? ______________________________

If NO, have you worn hearing aids in the past? ______________________________

Please list any recreational or occupational noise exposure: ______________

____

Do you have any of the following symptoms:

Ear Pain: Yes_____ No_____ If yes, explain: ______________

____

Ear Pressure: Yes_____ No_____ If yes, explain: ______________

____

Ringing in the ears: Yes_____ No_____ If yes, explain: ______________

____

Vertigo or dizziness: Yes_____ No_____ If yes, explain: ______________

____

Patient signature: ______________________________ Date: ____________

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