**Algoma Hearing Centre**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: (d/m/y) \_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Health Card #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_ Insurance: DVA - WSIB - FNA - Private

Insurance #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical History

1. Ear Specialist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Referral given: No \ Yes

C. Otologic History:

1) Ear infections \ Disease: No \ Yes: Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2) Ear pain \ discharge: No \ Yes: Left \ Right \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3) Ear fullness \ facial numbness: No \ Yes: Left \ Right \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4) Dizziness \ Imbalance: No \ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5) Ear surgery(s): No \ Left Right: Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6) Tinnitus (ringing in ears): No\ Left Right: Describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7) Noise Exposure: No \ Yes: Military \_\_\_\_ Industrial \_\_\_\_ Recreational \_\_\_\_

8) Hearing protection used: No \ Yes

D. Amplification History:

Do you currently use hearing aids: No \ Left Right: Year purchased\_\_\_\_\_\_\_\_\_