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

A. Ear Specialist: _____
B. 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_____