LISA REID AUDIOLOGY
WE'RE ALL EARS

LISA REID AUDIOLOGY INTAKE FORM

All questions contained in this questionnaire are strictly confidential

Date: D/_______M/________Y/________

Patient Information

Last Name ____ First Name ____________________________

Suite#_____________ Street Address____

City/Province_________________________ Postal Code_____________ Home Phone________________________

Work/ Cell Phone________________________________ Date of Birth: D/_______M/________Y/____________

Manitoba Health Reg # (9 digits)____________________________ (6 digits)______________________________

Present/Past Occupation ____

E-mail Address ______________________________________May we contact you by e-mail? Yes ☐ No ☐

Emergency Contact ______________________________________Relation to you __________________________

Emergency Contact Phone # ____

To get a better understanding of who you communicate with on a daily basis, please let us know who resides in the same household with you:

☐ Spouse/Partner ☐ Children ☐ Parent ☐ Roommate ☐ Live Alone ☐ OTHER __________________

Case History Information

Do you feel you have **Hearing Loss**? Yes ☐ No ☐

If Yes: In which ear? ☐ Right ☐ Left ☐ Both? For how long? ____

Have you ever had a **Hearing Test**? Yes ☐ No ☐ If yes: When? ____

Physician's Name _____________________________ Physician's Phone # _________________________________

Present Medications ____

Do you have or have you experienced any of the following? (Please check all that apply)

☐ Tinnitus (ringing in ears)
☐ Ear Infections
☐ Aural fullness
☐ Ear Surgery
☐ Head injury or trauma
☐ Dizziness or vertigo
☐ Family history of hearing loss
☐ Sudden onset hearing loss
☐ Allergies / Sinus
☐ Use a pace maker
☐ Exposure to loud noise at work _____________years
☐ Meningitis
☐ Radiation or chemotherapy
☐ Stroke OR Mini strokes
☐ Heart Attack

Please turn over →

Have you ever seen an **Ear, Nose and Throat Specialist**? ☐ Yes ☐ No Who? ______________________________

Prior use of Hearing Aids: ☐ Yes ☐ No Are you satisfied with them? ☐ Yes ☐ No

If you could improve something about your current hearing aids, what would it be? ______________________________

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Additional Information

Thank you for choosing Lisa Reid Audiology and placing your trust in us. Our goal is to provide superior hearing health care services to patients like you. We value your opinion and would appreciate you taking a moment to answer the following questions.

How did you hear about Lisa Reid Audiology? (**If more than one, please check all that apply**)

☐ Friend/Family Referral ☐ Doctor ☐ DVA List ☐ Internet

☐ Workplace Referral ☐ Sign on Building ☐ Walk in

☐ Facebook ☐ Newspaper Which publication? ______________________________

☐ Magazine ☐ Radio - Which station? ______________________________

☐ Other __________________________

What influenced you to make the appointment today?

☐ Reputation ☐ Location ☐ Promotional offer ☐ Appointment availability

Privacy Statement

We understand the importance of privacy to our patients, and are committed to safeguarding your privacy. The information requested on this form will only be used to send you information about our products and services, and will not be rented, sold, or exchanged with any third parties. Once entered into our database, access is strictly controlled and information is kept for the sole purpose of sending out mailings and creating statistical reports. If you would ever like to update your information, or if you ever change your mind and wish to stop receiving information about our products and services, please call us and your information will be updated or deleted from our records.

By this signature, I attest to having read and understood the foregoing Privacy Statement.

_____________________________________ _____________________________

Patient Signature **Date**