StyleTone Hearing Care, LLC

Doris A. Rapisardi, MAS-CCC-A
Founder/Director
Phone: 973-927-3433
Fax: 973-927-3473
Styletonehearing@gmail.com

Audiology Intake Form

Name: Date

Date of Birth:

Address

Home Phone Cell Phone Work Phone

Email Address ____ Do you have Blue Cross

Blue Shield PPO? ¨ Yes ¨ No Do you have Medicare? ¨ Yes ¨ No

If yes, ¨ Primary ¨ Secondary Marital Status ¨ Single ¨ Married ¨ Divorced ¨ Widowed ¨ Domestic Partner

Employer ¨ Full-Time ¨ Part-Time ¨ Retired ¨ Stay at Home

Occupation

Please send a copy of my test results to:

¨ Referring Physician: Include Name/Address/Phone

When was your last hearing test? ¨ Never had my hearing tested

Do you experience hearing loss? ¨ Yes ¨ No ¨ Not sure If yes, which ear(s)? ¨ Right ¨ Left ¨ Both

If you experience hearing loss, which best describes it?
¨ Gradual ¨ Fluctuating ¨ Sudden ¨ Congenital ¨ Longstanding

Which ear do you use to talk on the phone? ¨ Right ¨ Left

Do you have a history of hearing aid use? ¨ Yes ¨ No If yes, describe

Please list all allergies (food, medication, plastics etc.)

List current mediations and dosage

Do you use a pacemaker? ¨ Yes ¨ No

What is your expectation for today's appointment:

Name____

Have you experienced any of the following medical conditions?

☐ Diabetes	☐ Heart problems	☐ Vascular problems	☐ High blood pressure
☐ Cancer	☐ Stroke/TIA	☐ AIDS/HIV	☐ Head injury
☐ Autoimmune disease	☐ Genetic disorder	☐ Recent hospitalization	☐ Macular degeneration
☐ Mumps	☐ Measles	☐ Chicken pox	☐ Limb tingling/numbness
☐ Encephalitis	☐ Meningitis	☐ Tuberculosis	☐ Changes in cognition
☐ Paget's disease	☐ Double vision	☐ Difficulty swallowing	☐ Numbness around face
☐ Difficulty speaking	☐ Syphilis	☐ Von Recklinghausen NF	☐ Chronic headache
☐ Change in language		☐ Malaria	

Please check all that apply

☐ Dizziness Which best describes it? ☐ Constant ☐ Single episode ☐ Intermittent
☐ Lightheadedness

Accompanied by ☐ Hearing loss ☐ Limb weakness ☐ Tinnitus ☐ Ear fullness ☐ Double vision
☐ Tingling

☐ Tinnitus/ringing/noises If checked, ☐ Right ear ☐ Left ear ☐ Both ears (describe)

☐ Ear fullness/pressure If checked, ☐ Right ear ☐ Left ear ☐ Both ears

☐ Imbalance If checked, please describe

☐ Ear deformity If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Ear pain/discomfort If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Ear drainage (past 90 days) If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Meniere's disease Diagnosed by medical physician? ☐ Yes ☐ No

☐ Otosclerosis If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Hyperacusis (reduced tolerance to everyday sounds)

☐ Autophony (own voice sounds loud) If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ Ear infections If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears When?

☐ Family history of hearing loss (before the age of 50 years)? If checked, who?

☐ History of noise exposure If checked, please describe

☐ History of earwax buildup If checked, ☐ Right Ear ☐ Left Ear ☐ Both Ears

☐ History of ear surgery if yes, please describe

☐ Recent change in hearing If checked, ☐ Right ☐ Left

☐ Head trauma If checked, please describe

☐ Exposure to chemicals/drugs associated with hearing loss, please describe

____ ____________________