BOW RIVER HEARING

Case History Form

General Information

I. Patient Information

Last Name	First Name	Middle Name (s)
Mailing Address		City or Town
Province	Country	Postal Code
Date of Birth *(dd-mm-yyyy)*	Gender ☐ Male ☐ Female ☐ Not Listed: ______	
Family Doctor	Health Care Number	Occupation
Home Phone	Mobile Phone	Email
How did you hear about us?	What is to your preferred contact for appointment reminders? ☐ Text ☐ Email ☐ Phone	
What brought you in today?		

I. Alternate Contact Information

Name		Do you want to make this as your primary contact? ☐ Yes ☐ No
Relationship	Phone	Email

General Medical History

Please check all applicable:

☐ Diabetes ☐ Seizures ☐ Allergies ☐ Arthritis ☐ Heart Disease ☐ Stroke ☐ Blood Thinners ☐ Sinus Problems

☐ Cancer ☐ HIV ☐ High Blood Pressure ☐ Dementia/Memory Issues Other (please specify) ______

Do you exercise regularly? ☐ Yes ☐ No

Ear-Related Medical History

Please check all applicable:

☐ Wax buildup ☐ Family history of hearing loss ☐ Sudden change in hearing ☐ History of noise exposure (occupational or recreational)

☐ Ear infections ☐ Ear or Mastoid Surgery ☐ One-sided hearing loss ☐ Dizziness/vertigo/balance problems

☐ Tinnitus (eg. ringing/buzzing/hissing) Other (please specify) ______

Do you have any sensitivity to certain and/or loud sound(s)? ☐ Yes ☐ No If yes, please specify: ______

Have you had a hearing test before? ☐ Yes ☐ No

Have you used hearing aids before? ☐ Yes ☐ No

Hearing Health Assessment

I. Situations

Please check all situations in which you have hearing difficulties:

☐ Religion ☐ Work ☐ Restaurant ☐ Social gatherings
☐ Music ☐ Party ☐ Telephone ☐ Spouse/partner
☐ Travel ☐ Family ☐ Television ☐ Driving
☐ Outdoors Other (please specify) ____________________

____

II. Emotions

Please check all emotions that you have felt in these situations:

☐ Isolated ☐ Stressed ☐ Disappointed ☐ Misunderstood
☐ Confused ☐ Insecure ☐ Frustrated ☐ Inadequate
☐ Angry ☐ Anxious ☐ Ashamed ☐ Embarrassed
☐ Scared ☐ Depressed ☐ Withdrawn ☐ Vulnerable

Other (please specify) ____________________

III. Priority & Motivation

If hearing aids are part of your treatment, which of the following factor is most important to you (please rank)?

	1 Most Important	2	3 Least Important
Sound Quality	☐	☐	☐
Visibility	☐	☐	☐
Cost	☐	☐	☐

How motivated are you to address the issues that brought you in today?

1 Not Motivated	2	3	4	5 Very Motivated
☐	☐	☐	☐	☐

By signing below, I certify that all information provided above is true and correct to the best of my knowledge. I have read and understood the above information and I hereby give my hearing provider permission to treat my concerns.

Patient Signature
(For electronic signature, please type your name.)

Date *(dd-mm-yyyy)*

Additional Consent (please complete this if requested by your provider)

I. Patient Consent to Cerumen (Ear Wax) Removal

• In order to provide audiological intervention, cerumen (ear wax) must be removed from your ear canals. The presence of cerumen may prevent access to the ear canal for audiological care such as audiological assessment or earmold impression taking. Cerumen may also impact the effectiveness of hearing instruments. Extraction/removal is recommended. Every precaution will be undertaken to avoid discomfort or adverse results. The procedure can be discontinued at any point by the patient, companion, or hearing provider.
• Methods of removal may include curette, suctioning, irrigation or the use of drops.
• Risks to cerumen removal include, but are not limited to: injury to the ear canal, perforation of the eardrum (causing a hole or rupture of the eardrum), worsening/aggravation of chronic problems related to presence of 'fluid' in the middle ear, possible damage to the small bones of the middle ear, failure to remove the blockage.

Patient Signature
(For electronic signature, please type your name.)

Date *(dd-mm-yyyy)*

II. Patient Consent to Earmold Impression

• In order to provide audiological intervention, the hearing provider may need to take an impression of your ear(s).
• Every possible precaution will be undertaken to avoid discomfort or adverse results. Taking an impression includes introducing material into your ear(s) and removing it to get a physical representation of the ear canal. Risks associated with taking an ear impression may include: pushing earwax (cerumen) further into the ear canal, bleeding in the ear canal or from the eardrum, creating a hole in the eardrum or inner ear, impact on previous surgical procedures such as patching of an eardrum, worsening of certain conditions such as Meniere's disease, skin irritations or conditions within the external ear or canal, filling the middle ear with impression material that cannot be removed in the office.

Patient Signature
(For electronic signature, please type your name.)

Date *(dd-mm-yyyy)*