BENTLEY HEARING SERVICES

Adult Registration Form

Name: _____ Telephone: _____

Date of Birth: _____ Cell: _____

Address: _____ Email: _____

City: _____ Preferred: □ Email □ Phone

Postal Code: _____ Receive eNewsletter: □ Yes □ No

Family Doctor: _____

What motivated you to set today's appointment?

_____

_____

Do you have difficulties hearing? □ Right □ Left □Both

Do you hear better in one ear? □ Right □ Left

How long have you noticed the hearing loss? _____

Was the hearing loss: □ Sudden □ Gradual

In which situations do you have difficulty hearing?

□ Groups/Noise □ Church □ Television □Telephone □Meetings

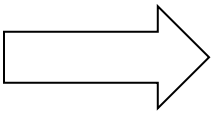
Do you have ringing or buzzing (tinnitus) in the ears? □ Right □ Left □ Both

If yes, how long have you noticed this? _____

Do you have any problems with dizziness? □ Yes □ No

Would you describe this as: □ Room spinning □ Imbalance

Continue onto back page.



Have you had any exposure to loud noise? □ Yes □ No

□ Factory Work □ Truck Driver □ Hunting □ Motorcycle

□ Snowmobile □ Fire Arms □ Other _____

Do you have a history of ear infections □ Yes □ No

Have you had any problems over the past year? □ Yes □ No

Is there a family history of hearing loss? □ Yes □ No

If yes, please provide details _____

Have you ever had a head injury? □ Yes □ No

Have you seen an Ear, Nose and Throat Specialist? □ Yes □ No

If yes, reason for the assessment _____

Have you ever had surgery on your ears? □ Yes □ No

Is yes, please provide details _____

Please mark if any of the following apply to you:

□ Heart Problems □ Diabetic □ Multiple Sclerosis □ Meniere's □ Epilepsy

Are you currently taking any medication? □ Yes □ No

Please list _____

Have you ever used a hearing aid? □ Yes □ No

If yes, how old is your current hearing aid _____