CELESTIAL
HEARING SOLUTIONS

2001 E Lohman Ave #112 Las Cruces, NM, 88001
Toll Free: (877) 372-7730 Email: celestialhearing@gmail.com

Hearing Health Report

Patient's Name: _____ Today's Date: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ E-mail: _____

Occupation: _____ ☐ Past ☐ Present

Insurance Carrier : _____ I.D . No./Policy No: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Observing Party : _____ Relationship: _____

Name of Family Physician: _____

Permission to release a copy of test information to physician? ☐ Yes ☐ No

---

How did you hear about us?

☐ Mail ☐ Phone ☐ Newspaper ☐ Yellow Pages ☐ Television ☐ Web ☐ Physician ☐ Referral: _____

Hearing Health History:

Do you have any allergies: ☐ Yes ☐ No If yes, please list _____

_____

Are you an insulin-dependent diabetic: ☐ Yes ☐ No

Are you currently taking any medication: ☐ Yes ☐ No If yes, please list _____

_____

CELESTIAL
HEARING SOLUTIONS

2001 E Lohman Ave #112 Las Cruces, NM, 88001
Toll Free: (877) 372-7730 Email: celestialhearing@gmail.com

Hearing Health Report (cont)

Do you have arthritis: ☐ Yes ☐ No

Do you have ringing in your ears: ☐ Yes ☐ No If yes, which ear _____

Have you previously had a hearing test: ☐ Yes ☐ No If yes, by whom _____ Date: _____

Have you received any medical or surgical treatment for hearing loss?: ☐ Yes ☐ No

If yes, when? _____ Physician/ENT: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Additional information about treatment: _____

_____

Amplification History:

Are you a current hearing aid wearer? ☐ Yes ☐ No Type/Brand: _____

Ear fitted: ☐ Both ☐ Left ☐ Right

If yes , and you could improve something about your current hearing instruments, what would that be? _____

_____

Do you know anyone who wears hearing aids? : ☐ Yes ☐ No If yes, who? _____

Hearing Care Professional: _____ License No: _____