# Central Pennsylvania Eye & Ear
**620 N. Third Street, Harrisburg, PA 17101**

**Name____________________________________________Birthdate__________Age____________**
**Address__________________________________City _____________________Zip______________**
**Phone Numbers: Home________________Office_________________Cell_______________________**
**Email address:_____________________________________________________________________**
**Preferred Method of Contact__________________________________________________________**
**Primary Care Physician Name:________________________________________________________**
**Address________________________________________________________________________**
**Sign here for approval to send a report to your physician:________________________________**
**How did you hear about our office?______________________________________________________**
**Reason for today's visit_________________________________________________________________**

**Medical & Hearing History**

**Current Health problems (High Blood Pressure, Diabetes, Heart Problems):__________________**
__________________________________________________________________________________
__________________________________________________________________________________
**List medications you are taking:________________________________________________________**
__________________________________________________________________________________
**Recent surgeries:_____________________________________________________________________**
**History of Ear disease, surgery or other ear problems:_______________________________________**
__________________________________________________________________________________
**Do you have dizziness, vertigo, or balance problems?_______________________________________**
**Do you have tinnitus (ringing, buzzing, hissing in ears)?_____________________________________**
**If yes, which ear?__________Since when?_______Frequency & duration___________________**
**How long have you had a problem hearing?_______________________________________________**
**Which ear hears /understands better?____________________________________________________**
**Has a doctor ever had to remove the wax from your ear?_____________________________________**
**If yes, when was the last time & how often is this required?_________________________________**
**In the past 3 months, have you had pain in either ear?________________________________________**
**If yes, what was the cause and treatment?_______________________________________________**
**In the past 3 months, have you noticed any drainage from either ear?__________________________**
**Describe any history of noise exposure____________________________________________________**
**Are you currently wearing hearing aids?___________________________________________________**
**If yes, are they helping you hear better?__________________________________________________**
**If no, are you willing to try hearing aids to help you hear better?_____________________________**
**List the three listening situations which give you the most difficulty or where you need the most improvement in your hearing:**
**1)**_________________________________________________________________________________

____________________________________________________________________________________

**2)**_________________________________________________________________________________

____________________________________________________________________________________

**3)**_________________________________________________________________________________

___________________________________________________________________________________

**Signature________________________________Date_________Dispenser___________________________**