

CONSTANCE BROWN HEARING CENTERS
Industrial Hearing Questionnaire

Date	PATIENT INFORMATION				CBHC#
Last Name		First Name			MI
Preferred Nickname		Preferred Pronouns: she/her/hers he/him/his they/them/their zie/hir/hirs			
Birth Date	Age	Legal Gender	F	M	Spouse's Name
Address					
City		State	County	Zip	
Home Phone	Cell Phone		Work Phone		Leave message Y N
Email		Preferred contact: Home Cell Work Email			
Employer		Job Title/Dept:			
Race/Ethnicity: American Indian Asian Black or African American Hispanic or Latino Mixed MENA (Middle Eastern or North African) Pacific Islander White Other					
HOW DO YOU RATE YOUR HEARING?					
Right Ear:	Excellent	Good	Fair	Poor	
Left Ear:	Excellent	Good	Fair	Poor	
Were you exposed to noise in the last 14 hours?					
	Yes	No			
If so, did you use hearing protection?					
	Yes	No			
Do you wear hearing protection at work?					
	Yes	No			
Which type of hearing protection do you use?					
	Plugs	Muffs			
Does anyone in your family have hearing loss?					
	Yes	No			
Do you have a cold or allergy symptoms today?					
	Yes	No			
Have you ever had a hearing test?					
	Yes	No			
If so, where?			When?		
CHECK WHICH OF THE FOLLOWING ACTIVITIES YOU ARE OR HAVE BEEN INVOLVED IN					
Shooting		Farm Machinery			
Auto Racing		Loud Music			
Power Saw		Power and Carpentry Equipment			
Military Service		Previous Noisy job			
Other					
Do you wear hearing protection when engaged in the above activities?					
	Yes	No			
If so, which type of hearing protection do you use?					
	Plugs	Muffs			
CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING					
Ear Surgery		Serious Illness affecting your hearing			
Ringing in the ears		Head injury			
Ear infections / ear pain		Dizziness			
Allergies / Sinus problems					

PLEASE READ AND COMPLETE REVERSE SIDE - SIGNATURES REQUIRED

CONSTANCE BROWN HEARING CENTERS

Date	Patient Name	CBHC#
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AUTHORIZATION AND RELEASE

By signing this consent form I acknowledge that I have read, understand, voluntarily consent to and authorize the administration and cost of all services for myself and my dependents.

Signature X _____ **Date** _____

RELEASE / OBTAIN RECORDS / INFORMATION

I authorize Constance Brown Hearing Centers to release/obtain verbally, electronically and/or in writing confidential information obtained during the course of my examination and/or treatment to any person or entity including my insurance carrier, employer (if treatment is related to employment), and/or other healthcare provider(s) for purposes of treatment, payment of charges, quality assurance and utilization review. I understand that should I choose not to release my records to a specific entity and/or person(s) I must specifically state so in writing. This assignment and authorization will remain in effect until revoked in writing by me.

Please also share my records with (name & address):

Physician

Spouse

Family Member

School

Other

Signature X _____ **Date** _____

RECEIPT OF PRIVACY PRACTICES

By signing this consent form I acknowledge that a copy of the Notice of Privacy Practices of Constance Brown Hearing Centers is available to me upon request.

Signature X _____ **Date** _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of our Notice of Privacy Practice, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barrier prohibited obtaining the acknowledgement
- Other (please specify)