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				

EMERGENCY CONTACT				
First & Last Name		Relationship		
Address				
City		State		Zip
Best Phone Number to Call in Case of Emergency				
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#

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)

Revised 7/2021