Uthe Hearing Aid & Audiology Centers, LLC

Phone: 515-278-2413 Fax: 515-278-5875

☐	807 Broad St. Grinnell, IA 50112		
☐	2478 E Euclid Ave DSM, IA 50317	☐	3839 Merle Hay Rd Ste 200 DSM, IA 50310
☐	404 Jefferson St. Pella, IA 50219	☐	1208 N Lincoln St. Knoxville, IA 50138

Personal Information

Name: _____ Date of Birth: _____

Preferred name: _____ ☐ Male ☐ Female ☐ Non-Binary

Address: _____

City: _____ State: _____ Zip code: _____

Primary phone number: _____ ☐ Home ☐ Cell ☐ Work

Secondary phone number: _____ ☐ Home ☐ Cell ☐ Work

May we contact you via phone? ☐ Yes ☐ No

Email address: _____

May we contact you via email? ☐ Yes ☐ No

Occupation/former occupation: _____

Retired: ☐ Yes ☐ No

Primary Physician: _____ Phone number: _____

Are you a veteran: ☐ Yes ☐ No

Referred by, or how did you hear about us? _____

Hearing History

*Select Yes or No for the following questions

Yes	No		Yes	No	
☐	☐	Previous hearing evaluation	☐	☐	History of head injury
☐	☐	Family history of hearing loss	☐	☐	Pain or discomfort in ear(s)
☐	☐	History of chronic ear infections	☐	☐	Dizziness and/or vertigo
☐	☐	History of falling	☐	☐	Pressure or fullness in ear(s)
☐	☐	History of ear surgeries	☐	☐	Tinnitus (ringing or buzzing)
☐	☐	Sudden or progressive loss in the last 90 days	☐	☐	Significant wax accumulation
☐	☐	Previous or current hearing aid use: _____			

Make: _____ Model: _____

☐ ☐ History of noise exposure

If yes, Explain: _____

Other: _____

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Medical History

*Select Yes or No for the following questions

Yes	No		Yes	No	
☐	☐	Auto Immune Disease	☐	☐	Hypertension
☐	☐	Osteoporosis	☐	☐	Meningitis
☐	☐	Migraine	☐	☐	Tobacco Use
☐	☐	Stroke	☐	☐	Tuberculosis
☐	☐	Cardio Vascular Disease	☐	☐	Depression
☐	☐	Dementia	☐	☐	Diabetes
☐	☐	Virus (CMV, HIV, Measles, Mumps, Rubella, etc.)	☐	☐	Vision Loss
☐	☐	Cancer: _____			

Type: _____ Treatment: _____

Other: _____

Emergency Contact Information

Emergency contact: _____

Relationship: _____

Phone number: _____

May we contact this person in an emergency? ☐ Yes ☐ No

Chief complaint/ Reason for visit:

Consent for Treatment

I hereby consent to receive services from Uthe Hearing Aid and Audiology Centers, LLC. This consent encompasses procedures including, but not limited to, diagnostic evaluation, rehabilitative treatment, earwax removal, and completion of earmold impressions. I acknowledge I read and understand this consent is valid and will remain in effect as long as I receive services from Uthe Hearing Aid and Audiology Centers, LLC.

Signature: _____ Date: _____