Fine Hearing Care
Come home for your hearing healthcare

# Military Intake

Hearing Solutions

***Welcome to Hearing Solutions, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing as much as possible on this form.***

## PERSONAL INFORMATION

Patient's Name: _____
FIRST MIDDLE LAST

Mailing Address: _____
STREET # STREET APT/UNIT #

_____
CITY STATE ZIP

Preferred Name _____ Social Security Number: _____-_____-_____

Phone Number: _____ Cell:_____ Work:_____

Birthdate: _____/_____/_____ Age: _____ Gender: ☐ Male ☐ Female

Marital Status: ☐ Single ☐ Married ☐ Separated/Divorced ☐ Widowed

## MILITARY HISTORY

Military Branch: ☐ Army ☐ Navy ☐ Marines ☐ Airforce ☐ Coastguard ☐ Reserves ☐ Active

Dates of Service: Enlisted: _____ Discharged: _____

What was your M.O.S. during service? _____

What was your job title during service? _____ Code:_____

What noise were you exposed to in the military? _____

Did you have access to hearing protection while in service? ☐ Yes ☐ No
If yes, did you use the hearing protection that was available to you? ☐ Yes ☐ No
If yes, how frequently was it used? _____

Served During: ☐ WWII ☐ Korean War ☐ Vietnam War ☐ Gulf War ☐ Afghanistan War ☐ Iraq War

☐ Other: _____ ☐ None

Combat Activity: ☐ Yes ☐ No

What is your weapons hand preference? ☐ Left ☐ Right ☐ Both

Where have you worked since you left the military? _____

## OTOLIGIC HISTORY

How would you describe your hearing? ☐ Hearing is fine/No concern ☐ Difficulty hearing in noisy environments
☐ Difficulty hearing in group situations ☐ Able to hear but not clearly ☐ Difficulty hearing from a distance
☐ Unable to hear

Do you perceive hearing loss? ☐ Yes ☐ No
If yes, date hearing loss began: _____

Do you feel your hearing is better in one ear versus the other? ☐ Yes ☐ No

Have hearing aids ever been recommended? ☐ Yes ☐ No
Have you ever received hearing aids? ☐ Yes ☐ No
If yes, have they been worn? ☐ Yes ☐ No
If yes, which ear? ☐ Left ☐ Right ☐ Both

Have you ever had ear surgery? ☐ Yes ☐ No
If yes, please describe: _____

Do you have tinnitus? (ringing/noise in the ears) ☐ Yes ☐ No
If yes, in both ears? ☐ Yes ☐ No
Constant or Intermittent? _____
Describe what it sounds like: _____
Are you bothered: ☐ Not at all ☐ Mildly bothersome ☐ Moderately bothersome ☐ Severely bothersome
Date of onset: _____
Circumstances of onset: _____

Have you been exposed to noises recently, or post-service? (check all that apply)
☐ No, none apply ☐ Fire arms ☐ Aircraft noises ☐ Farm equipment ☐ Heavy equipment
☐ Power tools ☐ Motorcycles/recreational vehicles ☐ Other _____

## MEDICAL HISTORY

Please check if you have experienced any of the following: (Check all that apply)

| | | |
|---|---|---|
| ☐ Otosclerosis | ☐ Diabetes | ☐ High blood pressure |
| ☐ Stroke/TIA | ☐ Meningitis | ☐ Kidney or Renal Disease |
| ☐ Labyrinthitis | ☐ Cancer:_____ | ☐ Permanent Hearing Loss |
| ☐ Bell's Palsy | ☐ Measles | ☐ Cholesteatoma |
| ☐ Meniere's Disease | ☐ Ossicular dislocation/fixation | ☐ Sudden hearing loss |
| ☐ Radiation/Chemotherapy | ☐ Long Term IV antibiotics | ☐ Head Trauma |
| ☐ Barotrauma | ☐ Acoustic Neuroma | ☐ Dizziness/Imbalance |
| ☐ Autoimmune Disease | ☐ Thyroid Disease | |

☐ Other_____

## PLEASE READ AND SIGN

I _____, understand that I am here to take a hearing test for VA compensation purposes. I certify that the statements and information provided are true and correct to the best of my knowledge and belief. I further understand that the law provides severe penalties which include fine, imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

_____ _____

Signature Date

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