HEARING AID CENTER
CONFIDENTIAL MEMBER INTAKE FORM

Costco Warehouse Name and Number: ______________________ Today's Date: __________

MEMBER INFORMATION

First Name: ____________ M.I.:______ Last Name: ____________

Membership Number: ____________ Date of Birth: ____________

Street Address: ____________

City: ____________ State: ____________ ZIP Code: ____________

Primary Phone Number: ____________ Secondary Phone Number: ____________

Email: ____________ Spouse/Significant Other Name: ____________

Occupation: ____________ Retired Working

MEDICAL HISTORY

Certain types of medication can impact your hearing or may complicate taking an impression of your ear. Do you take any of the following types of medication? If so, please select the appropriate box(es) and list.

Blood Thinners Chemotherapeutic Agents Heart Medications Insulin Pain Relievers

____

____

As part of your hearing evaluation, you may come into contact with various materials. Are you allergic to any of the following?

Latex Nitrile Plastics Rubber Silicone Other ____________

Have you ever had medical/surgical treatment for your ears? Yes No

If yes, at what age? ____________ Type of surgery/treatment: ____________

Select any of the following conditions if you currently have or have had in the past.

Arthritis	Diabetes I or II	Meningitis	Scarlet Fever
Allergies	Hepatitis	Multiple Sclerosis	Seizures
Bell's Palsy	High Blood Pressure	Neuropathy	Stroke/TIA
Concussion/Skull Fracture	High Fever	Pacemaker	Tuberculosis
Depression/Anxiety	HIV	Parkinson's Disease	Vision Problem
Cancer	Measles/Mumps	Memory Issues	Other:
Type/Treatment:	Meniere's	Diagnosis:	____________
____________		____________	____________

Name: ____________

Date: ____________

HEARING HISTORY

Yes No Have you ever had your hearing tested? If yes:

When? ______________________ Where? ____

Was hearing loss detected? Yes No

Yes No Have you ever been fit with a custom-molded ear piece?

Yes No Is your hearing better on some days compared to other days?

Yes No Have you ever heard noises in your ears (e.g., buzzing, ringing, clicking, roaring)?

If yes, which ear(s)? Both Right Left Describe the sound you hear: ___________________________

How often? ____________________ Is it bothersome? Yes No

Yes No Have you ever been exposed to occupational or recreational noise (e.g., military, music, gunfire)?

If yes, describe: ____

Yes No Does anyone in your family have hearing loss? If so, who? ____

Yes No Have you seen a physician for your hearing?

If yes, what type of physician? Primary Care General Practitioner ENT Other

Yes No Have you ever tried a hearing aid(s)?

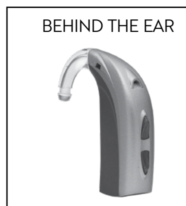
If yes: Do you wear the device(s) now? Yes No

If yes, what type of hearing aid(s) do you have? ____

Check the box of the picture that looks like your hearing aid(s):

OPEN FIT

BEHIND THE EAR



IN THE EAR

IN THE CANAL

COMPLETELY IN THE EAR

How long have you worn hearing aid(s)? ____

Which ear(s) do you wear the device(s) in? Both Right Only Left Only

Do you wear your hearing aid(s) regularly? Yes No

Do you hear better with your hearing aid(s)? Yes No

What do you like about your hearing aid(s)? ____

What do you dislike about your hearing aid(s)? ____

Yes No Have you ever purchased and returned a hearing aid?

If yes, why did you return it? ____

Is there any other information related to your hearing that you feel may be important for us to know?

____

____

HEARING NEEDS ASSESSMENT

Select the number, 1 being the worst and 10 being the best: How would you rate your overall hearing ability without hearing aids?

1 -------- 2 -------- 3 -------- 4 -------- 5 -------- 6 -------- 7 -------- 8 -------- 9 -------- 10
Worst Best

Please list the top three situations in which you would like to hear better. Be as specific as possible.
For example: I would like to hear my daughter on my cellphone when we talk every Sunday.

1. ____________________

2. ____________________

3. ____________________

Some things about hearing aids may seem more important than others. Please put a 1 by the most important consideration, a 2 by the next most important, a 3 by the third-most important, and a 4 by the least important.

______ Hearing aid size and the ability of others to (not) see the hearing aids

______ Improved ability to hear and understand speech

______ Improved ability to understand speech in noisy situations (e.g., restaurants, parties)

______ Cost of the hearing aids

Please choose the statement that is most true for you.

I prefer my hearing aids to be automatic so that I do not have to make any adjustments to them.

I prefer to adjust the volume and change the listening programs of my hearing aids as I see fit.

I do not have a preference.

Yes No I am interested in having remote appointments for follow-up services and adjustments on my hearing aids using a smart device such as a phone or tablet.

Yes No I am interested in listening to audio from a device such as a cellphone, tablet or TV through my hearing aids.

I would like to stream from the following type of device:

Android Cellphone	iPad	Other Audio Device: ____________
Android Tablet	iPhone	Other Cellphone: ____________
Computer	TV	Other Tablet: ____________

PRIVACY NOTICE

__________ Member Initials

I have reviewed the Costco Health Center Notice of Privacy Practices (the "Notice"), and understand that all of my medical information will be used by Costco Wholesale in accordance with the Notice.

INFORMATION STATEMENT

__________ Member Initials

To provide a custom-fitted hearing aid, an accurate impression of the ear canal must be made. In some instances there may be some minor discomfort involved during the insertion of the impression material and the subsequent removal of the finished impression. Occasionally, there may also be some temporary aftereffects that might include: throbbing, abrasion to the ear canal, redness, soreness, hematoma or bleeding. Although rare, if a problem should occur, you should seek proper medical treatment.

IMPORTANT MEDICAL CONSIDERATIONS FOR A HEARING AID FITTING

WARNING: When to See a Doctor

If you have any of the problems listed below, please see a doctor, preferably an ear-nose-throat doctor (an ENT).

- Your ear has a birth defect or an unusual shape. Your ear was injured or deformed in an accident.
- You saw blood, pus, or fluid coming out of your ear in the past 6 months
- Your ear feels painful or uncomfortable
- You have a lot of ear wax, or you think something could be in your ear
- You get really dizzy or have a feeling of spinning or swaying (called vertigo)
- Your hearing changed suddenly in the past 6 months
- Your hearing changes: it gets worse then gets better again
- You have worse hearing in one ear
- You hear ringing or buzzing in only one ear

FOR STAFF ONLY

I have reviewed the Confidential Case History and Information Statements with the member.

HAC Licensed Staff Signature: ________________________ Date: ____________

Title: ________________________

Dispenser Stamp/Sticker:

License #: ________________________