

Do you wear Hearing Aids? If so, Please fill out this form

Patient's Name: _____ Date of Birth: _____.

Address: _____

City _____ State _____ Zip _____.

Phone _____ Email _____.

Hearing Aid Questionnaire:

What ear do you wear a hearing aid on? Both Right Left

What brand is your hearing aid(s)? _____.

Is your hearing aid under warranty still? _____.

How old is your hearing aid? _____.

Are your hearing aids functioning properly? _____.

Are you experiencing any pain or discomfort in your ears? Yes No

Have you had any ear infections in the past 90 days? Yes No

When was your previous hearing test? _____.

If you could improve something about your current hearing aids what would it be? _____.



DELTA HEARING

Please contact Delta Hearing for all your
Hearing Healthcare needs.

941-702-8321