



AMERICA HEARS

Patient Health History & Medical Waiver

Last Name _____ First Name _____ Date _____

Address _____ City _____ State _____

Zip _____ Phone () _____ Date of Birth _____

America Hears "Freedom" hearing aids are suitable for most adults who suffer from diminished hearing due to environment or age. They are not suitable where disease, trauma and or genetic malformation contribute to the loss of hearing, nor are they suitable for children. All of these cases should be taken to an Ear, Nose and Throat medical doctor (E.N.T., MD). In compliance with the FDA and State regulations as well as for your personal protection and safety we require you to answer either YES or NO to the list of physical conditions stated below:

Visible congenital or traumatic deformity of the ear	<input type="checkbox"/>	_____ YES _____ NO
Active drainage from the ear within the previous 90 days	<input type="checkbox"/>	_____ YES _____ NO
Sudden or rapidly progressive hearing loss within the previous 90 days or a history of this symptom	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	_____ YES _____ NO
Acute or chronic dizziness	<input type="checkbox"/>	_____ YES _____ NO
Surgical or medical procedure(s) involving the ear	<input type="checkbox"/>	_____ YES _____ NO
Visible evidence of cerumen(ear wax) accumulation or a foreign body in the ear canal	<input type="checkbox"/> <input type="checkbox"/>	_____ YES _____ NO
Pain or any discomfort in your ears	<input type="checkbox"/>	_____ YES _____ NO
Stroke	<input type="checkbox"/>	_____ YES _____ NO
Any ringing or buzzing sounds in one or both ears	<input type="checkbox"/>	_____ YES _____ NO
Have you been exposed to any loud noises	<input type="checkbox"/>	_____ YES _____ NO
Have you recently had a cold or ear infection	<input type="checkbox"/> <input type="checkbox"/>	_____ YES _____ NO

If you have answered "YES" to any of the conditions listed above, you may be required to provide our company with a medical recommendation form that has been signed by the examining physician within the last (6) months.

I have been advised by _____ (hearing aid dispenser's name) that the Food and Drug Administration has determined that my best health interest would be served if I had a medical evaluation by a licensed physician (preferably a physician who specializes in diseases of the ear) before purchasing the hearing aid.

In signing below I acknowledge that I do not wish to have a medical evaluation before purchasing a hearing aid, that I understand and agree with the above statements, and that I am 21 years of age or older.

Client Name

Client Signature

Date

For America Hear's Use Only:

Bristol, PA Phone: 1-800-492-4515 Fax:1-800-332-3791

America Hears Location City/State/Phone

Hearing Instrument Specialist Signature / License Number / Date of Review