



THIS FORM IS REQUIRED BY PENNSYLVANIA STATE LAW

Client Health History

Name _____ Date _____ Date of Birth _____

Address: _____

America Hears 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 ___ Yes ___ No
Active drainage from the ear within the previous 90 days ___ Yes ___ No
Sudden or rapidly progressive hearing loss within the last 90 days or a history of this symptom ___ Yes ___ No
Acute or chronic dizziness ___ Yes ___ No
Surgical or medical procedure(s) involving the ear ___ Yes ___ No
Visible evidence of cerumen(ear wax) accumulation or a foreign body in the ear canal ___ Yes ___ No
Pain or any discomfort in your ears ___ Yes ___ No
Stroke ___ Yes ___ No
Any ringing or buzzing sounds in one or both ears ___ Yes ___ No
Have you been exposed to any loud noises ___ Yes ___ No
Have you recently had a cold or ear infection ___ 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.

Comments/Notes: _____

Medical Waiver

I have been advised by the professional signed below that the Food and Drug Administration and the state of Pennsylvania have 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 a hearing aid.

In signing below I acknowledge that i have been informed of the value of this medical examination. After such explanation, I voluntarily sign this waiver and state 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 19 years of age or older.

Client Name _____ Client Signature _____ Date _____

Audiologist or Hearing Instrument Specialist _____ Professional License Number _____ Date _____