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Yes ___ No ___

7. Have you ever had your hearing tested before?

When: _____ Where: _____

Recommendations: _____

Yes ___ No ___

8. Does anyone in your immediate family have a hearing loss?

Relative: _____ Age: _____

How significant? _____

Yes ___ No ___

9. Do you hear noises in your ears or head? L ___ R ___ B ___

Since: _____ Description: _____

Constantly _____ Intermittently _____

Yes ___ No ___

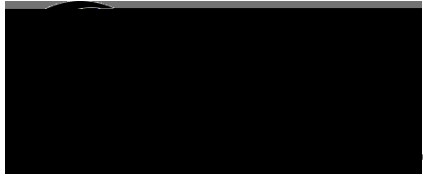
10. Do you ever have dizziness?

Since: _____ Description: _____

Constantly _____ Occasionally _____

Yes

! "#\$%&' () * + , - . / : ; < = > ? @ A B C D E F G H I J K L M N O P Q R S T U V W X Y Z [\] ^ _ ` { | } ~ ¡ ¢ £ ¤ ¥ ¦ § ¨ © ª « ¬ ® ¯ ° ± ² ³ ´ µ ¶ · ¸ ¹ º » ¼ ½ ¾ ¿ À Á Â Ã Ä Å Æ Ç È É Ê Ë Ì Í Î Ï Ñ Ò Ó Ô Õ Ö × Ø Ù Ú Û Ü Ý Þ à á â ã ä å æ ç è é ê ë ì í î ï ð ñ ò ó ô õ ö ÷ ø ù ú û ü ý þ ÿ



Harry Jersig Center 411 S.W. 24th Street San Antonio, TX 78207 (210) 431-3938

In signing this sheet I acknowledge that I have received a copy of the Notice of Privacy Practices dispensed by the Harry Jersig Center here at Our Lady of the Lake University.

Client/Parent/Guardian Signature

Date

Name of Patient:

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