**Patient Information**

**Today’s date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Name: Date of Birth: \_\_\_\_\_\_Age: \_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: State: ZIP: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: Home \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like a **copy of our findings** sent to your PCP / Family Doctor? Circle: Yes No

Name of Primary Care Physician/ Family Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What city is your PCP located in? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you: Working Retired Student

Is it Ok to text your cell phone & email? Yes No

**Emergency Contact:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Coverage and Benefit:** Would you like Audiology Services to check your insurance benefits for hearing aid coverage? **Yes No**

**Online: Please bring your Insurance Card with these forms to your appointment**

**In Person: Please attach your Insurance Card(s) to clipboard for us to make a copy.**

**What is the reason for your visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Who referred you to our office? How did you hear about us (circle all that apply).**

Colorado ENT Group (Dr. Kreutzer, Dr. Shah, Dr. Sohal, Dr. Fairmont)

Our Website Health Insurance MD: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Google Advertisement MD Assistant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Newspaper Phonebook Nurse: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ZocDoc Healthy Hearing Family/Friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Facebook Yelp Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Medical History**

**Please check any of the following medical conditions that you have or have had in the past:**

[ ]  Hearing loss [ ]  Diabetes

[ ]  Ringing/noise in ears or head [ ]  High Blood Pressure

[ ]  Dizziness or Vertigo [ ]  Dementia/Alzheimer’s/Cognitive Changes

[ ]  Ear infections, Pain, Drainage [ ]  Multiple Sclerosis

[ ]  Ear Surgery [ ]  Meniere’s Disease

[ ]  Brain Injury, Tumor, Stroke [ ]  Facial numbness

[ ]  Sound sensitivity [ ]  Cancer with Chemo

[ ]  Covid-19 [ ]  Arthritis

[ ]  Covid-19 vaccination [ ]  Acoustic Neuroma

[ ]  Otosclerosis [ ]  Kidney Disease, Thyroid Disease

**Hearing History**

Have you ever had a hearing test? \_\_\_\_\_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had ear surgery? \_\_\_\_\_\_\_\_\_\_ When/What for? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you concerned about wax? Yes No

**Which is your better ear? Right Left Unknown**

Family history of hearing loss? Yes No Unknown

If yes, who has hearing loss? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How fast did your hearing change? Sudden Gradual Unknown**

Has your hearing gotten worse over time? Yes No

Is this a work-related injury? Yes No Date of injury: \_\_\_\_\_\_

Do you have a history of ear infections? Yes No

**Please check any of the following which applies to you:**

[ ]  Worked in a noisy environment [ ] Hunting/Shooting [ ]  Flying (planes/helicopters…)

[ ]  Loud music/concerts [ ] Farming [ ]  Car accident with AIRBAG deployment

[ ]  Military [ ]  Power Tools [ ]  OtherNoise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check any of the following daily activities and functions that applies to you:**

[ ]  Difficulty understanding soft speech. [ ]  Missing natural sounds (birds, crickets, etc.).

[ ]  Difficulty understanding on the telephone. [ ]  Turn up the television or radio?

[ ]  Do you feel that people mumble? [ ]  Hear words but do not understand them?

[ ]  Difficulty hearing if you cannot see the speaker [ ]  Increased difficulty due to mask wearing?

[ ]  Family and friends telling you that you cannot hear.

[ ]  Do you have to ask people to repeat themselves?

[ ]  Difficulty understanding co-workers, clients, or customers.

[ ]  Difficulty hearing when background noise is present (restaurant, church, party, gathering).

**Hearing Aid History**

What is your experience with hearing aids? (Check all that apply)

[ ]  I have never visited an Audiologist or specialist to inquire about hearing aids.

[ ]  I have visited with an Audiologist or specialist to gather information, but I have not tried or purchased.

[ ]  I have tried hearing aids but returned the instruments.

[ ]  I have hearing aids but only wear them occasionally or not at all.

[ ]  I have hearing aids and wear them regularly.

How long have your worn hearing aids? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How old are your current hearing aids? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear 1 aid or 2? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear them all day? Yes No Part-time user

If you are coming in for a cleaning, adjustment, or programming is there a something specific you would like to tell us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Your current lifestyle is mainly:**

[ ]  Active Lifestyle (frequently in background noise)

[ ]  Causal Lifestyle (Occasional background noise)

[ ]  Quiet Lifestyle (limited background noise)

[ ]  Very Quiet Lifestyle (Rarely in background noise)

Do you have (circle): iPhone Android No idea/Do not use

**What do you consider your main problem?**

[ ]  Hearing

[ ]  Tinnitus-Ringing in the ears

**Tinnitus**

Do you have ringing in your ears/head (tinnitus)? Yes No Sometimes

Is the tinnitus in your: Right ear Left ear Both ears Head

Did the tinnitus begin: Sudden Gradual Unknown

Is the tinnitus: Constant Comes & Goes

Is the tinnitus bothersome? Yes No Sometimes

Describe the sound you hear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When did the tinnitus start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you think the tinnitus was related to any other medical or environmental condition?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does the tinnitus Pulse with your heartbeat? Yes No

If your tinnitus triggered by head or neck movement? Yes No

Have you tried tinnitus treatment before? Yes No

***Does your tinnitus…***

Make it difficult to sleep at night? Yes No Sometimes

Make it difficult to concentrate while reading? Yes No Sometimes

Make it difficult to relax in a quiet room? Yes No Sometimes

Cause you to feel angry? Yes No Sometimes

Cause you to feel stressed? Yes No Sometimes

Cause you to feel sad? Yes No Sometimes

**Do you have sound tolerance problems?** Yes No Sometimes

**NOTICE OF PRIVACY PRACTICES**

This notice describes how medical information about you may be used and shared and how you can access this information. Please look at it carefully.

**Audiology Services** is required by law to maintain the privacy of health information and provide you with notice of its legal duties and privacy practices concerning your health information. Therefore, you have a right to a complete paper copy of our Notice of Privacy Practices. If you have any questions about any part of this notice or would like a more detailed explanation of these rights, please get in touch with Audiology Services at 255 Union Blvd., Suite 220, Lakewood, Colorado, 80228, (303)462-4900.

**Audiology Services** collects health information from you and stores it in a chart on a computer. This is your medical record. The medical history is the property of **Audiology Services**, but the information in the medical record belongs to you.

Your information is used and protected with the strictest confidence. Your information will only be transmitted to other parties, for example, insurance companies, lawyers, or other medical providers, with your written consent (mailed letter, email, fax, text). Regarding treatment, if another treatment provider is treating you, we may discuss the information we may disclose about you in such circumstances could, include your diagnosis, hearing test results, etc. We also may use your information to process your insurance claim. If someone other than you or your insurance company needs copies of your file, we will need your written authorization to release this information to that person or business.

We may also contact you by phone, email, mail, or text to give you appointment reminders or information about other treatments, health-related benefits, and services that may interest you. We may also contact you by mail or email with **Audiology Services** Newsletters.

I have been informed of the policies by which my information is used and transmitted. Therefore, I authorize releasing any medical or other information necessary to process this claim. I also allow payment of medical benefits to **Audiology Services** for services rendered.

Signature of Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_