Hearing HealthCare Centers

General Information Date: _____

Full Name: _____ Preferred Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

Email: _____ Date of Birth: _____ ☐Male ☐Female

Marital Status: ☐Single ☐Widowed ☐Married Name of Companion:_____

Employment Status: ☐Retired ☐Full Time ☐Part Time Occupation: _____

Snowbird Address (if applicable):

Address: _____ City: _____ State: _____ Zip Code: _____

Emergency Contact Information

Name: _____ Phone: _____ Relationship: _____

Insurance Information ****** Please allow us to copy your insurance cards ******

If you are not the primary insured please complete:

Name: _____ Date of Birth_____ Relationship: _____

Medical History

Primary Physician: _____ Phone: _____

May we send a copy of test results to your physician? (Medicare physicians automatically receive a report)

☐Yes ☐No

Please circle any of the following conditions that apply (including past and present conditions):

Diabetes	Self	Family	None	Heart Problems	Self	Family	None
Hypertension	Self	Family	None	Cancer	Self	Family	None
Thyroid problems	Self	Family	None	Hearing Loss	Self	Family	None

Please provide a list of medications for us to copy for your file, or list current medications, dosages and frequency, along with over the counter medications and vitamin supplements below:

_____

_____

_____

1. In general, would you say your health is: *(circle number)*

Excellent	Very Good	Good	Fair	Poor
1	2	3	4	5

The following items are about activities you might do during a typical day. Does your health now limit you in these activities?

	Yes, a lot	Yes, a little	No, not at all
2. Lifting or carrying groceries	1	2	3
3. Climbing several flights of stairs	1	2	3
4. Walking several blocks	1	2	3

Hearing HealthCare Centers

5. During the past 4 weeks, how much difficulty did you have doing your work or other regular daily activities as a result of your physical health?

None at all	A little bit	Moderately	Quite a bit	Couldn't work
1	2	3	4	5

6. During the past 4 weeks, to what extent have you accomplished less than you would like in your work or other daily activities as a result of emotional problems?

None at all	A little bit	Moderately	Quite a bit	Extremely
1	2	3	4	5

7. During the past 4 weeks, to what extend has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors or groups?

None at all	A little bit	Moderately	Quite a bit	Extremely
1	2	3	4	5

8. How much bodily pain have you had during the past 4 weeks?

None	Very mild	Mild	Moderate	Severe	Very Severe
1	2	3	4	5	6

For each question, please give the answer that describes the way you have been feeling during the past 4 weeks.

	All of the time	Most of the time	A good bit of the time	Some of the time	Little of the time	None of the time
9. Have you felt calm and peaceful?	1	2	3	4	5	6
10. Did you have a lot of energy?	1	2	3	4	5	6
11. Have you felt downhearted and blue?	1	2	3	4	5	6
12. Have you been happy?	1	2	3	4	5	6

About your Ears

Deformity of the ear?	___ Yes	___ No	
Do you have sudden pain in your ears?	___ Yes	___ No	
Sudden or long-term dizziness?	___ Yes	___ No	
Sudden/rapid hearing loss in the past 90 days?	___ Yes	___ No	
Hearing loss in one ear that occurred in the past 90 days?	___ Yes	___ No	
Have you ever had wax removed from your ears?	___ Yes	___ No	
Drainage from either ear in the past 90 days?	___ Yes	___ No	
Have you ever had ear surgery?	___ Yes	___ No	Date:_____
Which do you believe is your poorer ear?	___ Left	___ Right	___Not Sure/Same
Have you ever seen an ear doctor?	Name:_____		

Diseases of the ear Have you ever been diagnosed with the following conditions?

Meniere's	___Yes	___No	___Not Sure
Cholesteatoma	___Yes	___No	___Not Sure
Mastoiditis	___Yes	___No	___Not Sure
Labyrinthitis	___Yes	___No	___Not Sure
Otitis Media/Chronic ear infections	___Yes	___No	___Not Sure

Boulder	Broomfield	Colorado Springs	Ft Collins	Loveland	Longmont
4800 Baseline Rd	320 E 1st Ave	2105 Academy Cir	3726 S Timberline Rd	2902 Ginnala Dr	1515 N Main St
Suite E108, 80303	Suite 102, 80020	Suite 100, 80909	Suite 103, 80526	Suite 3, 80538	Suite 15, 80501
(303) 499- 3900	**(303) 464-8440**	**(719) 591-2463**	**(970) 221-5011**	**(970) 593-1509**	**(303) 776-8748**

Hearing HealthCare Centers

About Your Hearing

Do your friends or family complain that you do not hear well? ___ Yes ___No

What do they notice or how would they describe your hearing? _____

_____

When was your last hearing test? _____

Do you have ringing in your ears? ___ Yes ___ No Which ear? ___ Right ___Left ___Both

Please describe the sound_____

Have you been exposed to excessive noise? ___ Yes ___ No Veteran/Military? ___Yes ___ No

Please describe_____

Have you ever worn a hearing instrument? ___ Yes ___ No Date fit? _____

What brand/type? _____ Results? _____

Perception of Hearing Questionnaire

Please circle the answer that best describes how often these statements apply to you:

Does a hearing problem cause you to feel embarrassed when you meet new people?	YES	SOMETIMES	NO
Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES	SOMETIMES	NO
Do you have difficulty hearing when someone speaks in a whisper?	YES	SOMETIMES	NO
Do you feel handicapped by a hearing problem?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?	YES	SOMETIMES	NO
Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when listening to TV or radio?	YES	SOMETIMES	NO
Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	NO
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO

What situations do you believe are most impacted by your hearing loss?

_____

_____

Signature: _____ Date: _____

By signing this document you are affirming that all the information you have provided is accurate to the best of your knowledge.

Boulder
4800 Baseline Rd
Suite E108, 80303
(303) 499- 3900

Broomfield
320 E 1st Ave
Suite 102, 80020
(303) 464-8440

Colorado Springs
2105 Academy Cir
Suite 100, 80909
(719) 591-2463

Ft Collins
3726 S Timberline Rd
Suite 103, 80526
(970) 221-5011

Loveland
2902 Ginnala Dr
Suite 3, 80538
(970) 593-1509

Longmont
1515 N Main St
Suite 15, 80501
(303) 776-8748