

# CONTACT INFORMATION

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

## Patient Information

Prefix: (Circle One) Mr. Mrs. Ms. Dr. Preferred Name: \_\_\_\_\_

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Last First Initial

Mailing Address: \_\_\_\_\_  
Address City State Zip

Phone: \_\_\_\_\_  
Home Work Ext. Cell

May we leave a voice mail? YES NO May we contact you by email? YES NO

If yes, Email: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ PAST / PRESENT (circle one)

## Alternate Contact Information

Are you a winter resident? YES NO

If yes, name of park/community: \_\_\_\_\_

Approximate dates you are in Tucson From: \_\_\_\_\_ To: \_\_\_\_\_

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

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

## Referral Information

How did you find El Dorado Audiology? (Please check all that apply)

- AZ Daily Star       Internet Search       Yellowpages       Neighborhood Newsletter  
 AZ Jewish Post       Spotlight       Lovin Life       Perks State Emp Program

Physician: \_\_\_\_\_

Health Fair/Event: \_\_\_\_\_

Friend/Patient Referral: \_\_\_\_\_

Other: \_\_\_\_\_

# MEDICAL CASE HISTORY

Have you had a hearing test before?    Yes (date) \_\_\_\_\_    No

Why have you decided to have your hearing tested? \_\_\_\_\_

Do you currently wear hearing aids?    Yes (yrs worn) \_\_\_\_\_    No

If yes, do you have any problems with your current devices? \_\_\_\_\_

How would you rate your ability to hear and understand speech? (circle one)

No Difficulty

Moderate Difficulty

Severe Difficulty

Yes	No	
		Major Surgery? (within 6 months)
		Drainage from your ears? (within 90 days)
		Noticed a sudden change in hearing in one or both ears? (within 90 days)
		Any earaches? (within 90 days)
		Ever had any ear surgery?
		Ever had any head trauma, skull fracture, or concussion?
		Current smoker?
		Family history of hearing loss? If so, whom?
		Tinnitus (ringing in ear)? If so, how often?
		Loud noise exposure (e.g. military, music, industrial)? If so, explain.

**Circle if you have had or currently have any of the following conditions:**

- |                        |                     |                     |                   |
|------------------------|---------------------|---------------------|-------------------|
| Chronic Ear Infections | Vertigo (dizziness) | Scarlett Fever      | Mumps/Measles     |
| Heart Disease          | Stroke              | High Blood Pressure | Diabetes          |
| Kidney Disease         | Cancer              | Meningitis          | Depression        |
| Arthritis              | Dexterity Problems  | Memory Issue        | Vision Difficulty |

Drug Name	Taken for what condition?	How Often?

Yes	No	
		Ever had chemotherapy or radiation therapy?
		Currently take Lasix?
		Currently take large quantities of aspirin?
		Ever taken Streptomycin/Vanomycin/Gentomycin?

# Hearing Inventory "HHIE" for Patient

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

At El Dorado Audiology, it is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information about you.

Please answer the following questions by checking the appropriate response

	Yes	Sometimes	No
1. Does a hearing problem cause you to feel embarrassed when you meet people?	___	___	___
2. Does a hearing problem cause you to feel frustrated when talking to member of your family or a friend?	___	___	___
3. Do you have difficulty hearing when someone speaks in a whisper?	___	___	___
4. Do you feel burdened by a hearing problem?	___	___	___
5. Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	___	___	___
6. Does a hearing problem cause you to attend large group situations less often than you would like?	___	___	___
7. Does a hearing problem cause you to have arguments with family members?	___	___	___
8. Does a hearing problem cause you difficulty when listening to TV or radio?	___	___	___
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	___	___	___
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends ?	___	___	___

(To be completed by Audiologist:) HI Score \_\_\_\_\_

# Hearing Inventory "HHIE" for Companion

Your Name \_\_\_\_\_

Date \_\_\_\_\_

Patient Name \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

At El Dorado Audiology, it is our mission to find the best personal solution for each individual's communication needs. We will only be successful in reaching this goal if we take the time to compile the following information from the closest person to the patient.....you!

Please answer the following questions by checking the appropriate response

	Yes	Sometimes	No
1. Have you observed a situation where a hearing problem made him/her to feel embarrassed when meeting people?	___	___	___
2. Do you feel a hearing problem causes him/her to feel frustrated when talking to members of his/her family?	___	___	___
3. Have you noticed his/her difficulty hearing when someone speaks in a whisper?	___	___	___
4. Do you believe he/she is burdened by a hearing problem?	___	___	___
5. Are you concerned that a hearing problem causes him/her difficulty when visiting friends, relatives or neighbors?	___	___	___
6. Do you think a hearing problem causes him/her to attend large group situations less often than he/she would like?	___	___	___
7. Have you ever felt a hearing problem causes him/her to have arguments with family members?	___	___	___
8. Have you ever noticed a hearing problem cause him/her difficulty when listening to TV or radio?	___	___	___
9. Are you concerned that any difficulty with his/her hearing limits or hampers his/her personal and/or social life?	___	___	___
10. Have you observed that a hearing problem causes him/her difficulty when in a restaurant with relatives or friends ?	___	___	___

(To be completed by Audiologist:) HI Score \_\_\_\_\_