Colorado West Otolaryngologists, P.C.
Ear | Nose | Throat | Head & Neck
Facial Plastic & Reconstructive Surgery
Audiology & Hearing Aid Center

PHYSICIANS
Michael M. Trowbridge, MD
Duane O. Hartshorn, MD
Mark C. Griffin, MD
Matthew R. Swelstad, MD
Valerie H. McElroy, PA-C
Michael L. Hanson, PA-C
Alisha Raehl, PA-C
James A. Merrell, MD

AUDIOLOGISTS
Joe McDermott, Au.D., F-AAA, CCC-A
Jennifer Bebee, Au.D., F-AAA, CCC-A
Jeannette Sadler, Au.D., F-AAA
Cory Workman, B.S.

Hearing Health Assessment

TO BE COMPLETED BY PATIENT

Patient Name _____ DOB _____/_____/_____
First Last MI MM DD YYYY

How did you find out about us?

☐ Yellow Pages ☐ Internet ☐ Referred by Patient _____
☐ Advertisement ☐ Insurance ☐ Referred by Physician _____
☐ Consumer Seminar ☐ Employer ☐ Other _____
☐ Website ☐ Facebook

What would you like to accomplish at today's appointment? _____

_____

When was your last hearing exam? _____ By whom? _____

How long ago did you notice a decline in your hearing? ☐ Within 1 Year ☐ 1–5 Years ☐ 5–10 Years ☐ 10+ Years

Have you ever utilized a hearing solution? ☐ Yes ☐ No If yes, describe your satisfaction _____

_____

Which ear do you most often use on the telephone? ☐ R ☐ L ☐ Both ☐ Neither

Have you experienced a sudden or progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you ever had ear surgery? ☐ Yes ☐ No If yes, when:_____ Which ear:_____ Name of procedure:_____

Do your ears produce a significant amount of wax? ☐ Yes ☐ No Are you experiencing any pressure in your ears? ☐ Yes ☐ No

Have you had chronic ear infections? ☐ Yes ☐ No Have you ever had any trauma to the head? ☐ Yes ☐ No

Do you have a family history of hearing loss? ☐ Yes ☐ No

Do you have a history of any of the following?

☐ Measles ☐ Mumps ☐ Pneumonia ☐ Frequent Headaches ☐ High Fevers ☐ Meningitis

☐ Other (describe) _____

Patient dexterity ☐ Good ☐ Fair ☐ Poor Patient vision ☐ Good ☐ Fair ☐ Poor

Have you been exposed to excessive noise levels without hearing protection in any of the following situations?

☐ Workplace ☐ Military ☐ Firearms ☐ Music ☐ Motorcycles ☐ Lawnmower ☐ Other _____

Are there any specific features you are interested in for your hearing solution? _____

_____

THIS PORTION TO BE COMPLETED BY HEARING CARE PROFESSIONAL

- ☐ Quiet Conversation
- ☐ Door Bell
- ☐ Phone Ringing
- ☐ Alarms (Clock, Security, Timers, etc.)
- ☐ Home Telephone
- ☐ Driving
- ☐ Religious Services
- ☐ Adult Conversations
- ☐ Small Family Gatherings
- ☐ Quiet Restaurants
- ☐ Cell Phones
- ☐ Shopping
- ☐ Movie Theaters
- ☐ Health Clubs
- ☐ Small Group Meetings
- ☐ Conversations with Children
- ☐ Television
- ☐ Open/Reverberant Home
- ☐ iPod®/Personal Music Players
- ☐ Outdoor Activities
- ☐ Entertainment Venues (Casinos, Exhibit Halls, etc.)
- ☐ Busy Restaurants
- ☐ Frequent Social Gatherings
- ☐ Cell Phones
- ☐ Conference Calls
- ☐ Multimedia Connectivity (Home Theater, Computer, Phone, etc.)
- ☐ Travel & Airports
- ☐ Concerts & Arts
- ☐ Group Presentations

Desired lifestyle? ☐ Private ☐ Quiet ☐ Active ☐ Dynamic **Does the companion agree?** ☐ Yes ☐ No

What are the top 3 environments you would like to hear better in?

		SCALE OF 1–4 PRE	POST
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____

NOTES: