ELITE HEARING of Colorado Springs • Dr. Nichole Kovel, AuD • Dr. Carlee Michaelson AuD
4195 Centennial Blvd. Colorado Springs, CO 80907 • 719-633-2685 www.elitehearingofcoloradosprings.com

Name:_____Birthdate:_____

Soc. Sec # (military only)_____

Gender Identity: Man / Woman / Non-binary or Other **Biological Sex:** Male / Female

Employer:_____Occupation_____

Noisy environment? ____ Use of Heavy Machinery? ____ Firearms, Recreational noise? _____

Home Phone_____Cell Phone_____Other_____

Address:_____

(Street, City, State, Zip)

Please List who you live with _____

Email Address:_____(We do not share your email)

Marital Status: (Circle) Single Married Divorced Widowed

Emergency Contact Name/Relation:_____Emergency Contact Ph:_____

I give permission for the following communications to be used by Elite Hearing (circle all that apply):

Email / Text Messaging / Cell Phone (Calling) / Home Phone / US mail

STAY UPDATED THROUGH E-MAIL ON THE LATEST HEARING HEALTH INFORMATION (Circle) YES / NO

MY PREFERRED METHODS OF APPOINTMENT REMINDERS (Circle all that apply) TEXT / EMAIL / CALL

Would you like to have your Audiogram Report sent to you via e-mail? (Circle) YES / NO

INVOICES FOR PAYMENT DUE WILL ARRIVE VIA EMAIL AND US MAIL

Primary Physician:_____ Facility Name: _____
Phone Number: _____ Fax Number: _____

Referring Physician:_____ Facility Name: _____
Phone Number: _____Fax Number: _____

What brings you in to see us: (Please circle all that apply)

Hearing Loss Earwax Tinnitus (Ringing) Management Vertigo/Dizzy Hearing Protection Physician Referral
May Need Hearing Aids Current Hearing Aids Not Working Other:_____

Currently have/wear hearing aids? (Circle) YES / NO Brand, if known:_____

How did you hear about Dr. Kovel/Elite Hearing of Colorado Springs? (Circle)

Family/Friend Internet Print Ad Referral Direct Mail Other:_____

Signature _____ Date _____

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Basic Health History

1. **What brings you in today? (Please check all that apply)**

ϒ Hearing Loss ϒ Tinnitus/Ringing ϒ Vertigo/Dizziness
ϒ Difficulty understanding ϒ Healthy curiosity ϒ Hearing Protection
ϒ Purchase Hearing Aids ϒ PCP Referral ϒ Repair Current Hearing Aids
ϒ Family or friend recommendation ϒ Cerumen/Wax

2. **How long have you noticed this difficulty?**_____

3. **Do you take any of the following types of medications? (Please check):**

ϒ Blood pressure ϒ Heart disease ϒ Arthritis ϒ High Cholesterol
ϒ Erectile dysfunction ϒ Daily aspirin ϒ Blood thinning ϒ Rx Pain Medication

List all medications (or provide a list for us to copy)**:**

_____
_____

4. **Please check any of the following that you currently have or have had in the past:**

ϒ Severe Arthritis in Fingers ϒ Hepatitis ϒ Stroke/TIA
ϒ Alzheimer's ϒ High Blood Pressure ϒ Neurological Disorder
ϒ Bell's Palsy ϒ HIV or AIDS ϒ Parkinson's
ϒ Cancer, Type:_____ ϒ MRSA ϒ Scarlet Fever
ϒ Depression/Anxiety ϒ Malaria ϒ Sinusitis
ϒ Dementia ϒ Measles/Mumps ϒ Shingles, Location:_____
ϒ Diabetes, Type:_____ ϒ Meniere's disease ϒ Meningitis
ϒ Thyroid (Hypo/Hyper) ϒ Concussion/TBI ϒ Current ear pressure/pain
ϒ Severe Vision Loss ϒ Heart Condition ϒ Vertigo
ϒ Heart Attack ϒ High Cholesterol ϒ Ringing in the ears
ϒ Other:_____

5. **Tobacco Use: ϒ Never ϒ Quit/Date:_____ ϒ Current Smoker/How much?_____**

6. **Please rank the following in order of importance if hearing aids are recommended for you:**

(1-4, 1 being the most important)

___ Overall Sound Quality ____ Reliability ____ Style/Appearance ____ Expense

By signing below you agree that we can check on your hearing healthcare periodically.

- **Such as appointment reminder calls**
- **New technology updates**

Signature _____ **Date** _____

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Patient Hearing Questionnaire

Name: _____

We would like to ask you a few questions to better understand your listening lifestyle and how we might improve your quality of life.

Does a hearing problem...	Always	Sometimes	Never
Cause you to have to ask people to repeat themselves?	A	S	N
Cause you to have difficulty hearing when in the presence of background noise?	A	S	N
Cause you to have difficulty hearing women's or children's voices?	A	S	N
Cause you to have difficulty following conversations in a restaurant?	A	S	N
Cause you to turn up the television or radio?	A	S	N
Cause you to hear people speak but fail to understand what they are saying?	A	S	N
Hinder ease of conversation during outdoor activities?	A	S	N
Cause you to feel as though others mumble?	A	S	N
Make it difficult for you to converse on a landline telephone?	A	S	N
Make it difficult for you to converse on a cell phone?	A	S	N
Limit or hamper your personal or social life?	A	S	N
Cause you to feel stressed or tired when listening for long periods of time?	A	S	N
Create difficulity while riding with others in the car?	A	S	N

Please select your current and (if different) desired lifestyle

☐ **Active Lifestyle** (Frequent background noise) ☐ **Casual Lifestyle** (Occasional background noise)

☐ **Quiet Lifestyle** (limited background noise) ☐ **Very Quiet Lifestyle** (Rare background noise)

Please provide the top three listening situations where you would like to hear better.

1. _____
2. _____
3. _____

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Companion Questionnaire: *Please give to your spouse, family member or friend*

Name:_____**Name Of Patient:**_____ _____
Relation to Patient:

We would like to ask you a few questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

Does a hearing problem...	Always	Sometimes	Never
Make it difficult for your companion to converse on the telephone?	A	S	N
Cause you to complain that your companion turns up the television or radio too loud?	A	S	N
Cause your companion to have difficulty following conversations in a restaurant?	A	S	N
Limit or hamper your companion's personal or social life?	A	S	N
Cause your companion to have to ask people to repeat themselves?	A	S	N
Cause your companion to have difficulty hearing when in the presences of background noise?	A	S	N
Cause your companion to have difficulty hearing women's or children's voices?	A	S	N
Cause your companion to hear people speak but fail to understand what they are saying?	A	S	N
Cause your companion to feel as though others mumble?	A	S	N
Cause your companion to feel stressed or tired when listening for long periods of time?	A	S	N

Please select your companion's current and (if different) desired lifestyle

☐ **Active Lifestyle (Frequent background noise)** ☐ **Casual Lifestyle (Occasional background noise)**
☐ **Quiet Lifestyle (Limited background noise)** ☐ **Very Quiet Lifestyle (Rare background noise)**

Please provide the top three listening situations where you would like your companion to hear better.

1. _____
2. _____
3. _____

Patient Name:_____**DOB:**_____