Denison Hearing

Doctor of Audiology Hearing Healthcare

Name: _____ **Date of Birth:** _____ **Date:**_____

Phone Number: _____ **Email:**_____

Primary Care Physician: _____

What motivated you to come in today? _____

Previous Hearing Test: ☐Y ☐N **When?** _____ **Hearing Aid User:** ☐Y ☐N

Tinnitus (Noises/Ringing in the ears): ☐Y ☐N **If Yes, Which Ear?** ☐R ☐L ☐Both

Dizziness: ☐Y ☐N **Family History of Hearing Loss:** ☐Y ☐N

Ear Fullness/Pressure: ☐Y ☐N **If Yes, Which Ear?** ☐R ☐L ☐Both

Ear Pain: ☐Y ☐N **If Yes, Which Ear?** ☐R ☐L ☐Both

History of Ear Infections: ☐Y ☐N **History of Ear Surgery:** ☐Y ☐N

Allergies:_____

Medications:_____

Falls in The Past Year: ☐ Y ☐N **If Yes, How Many?**_____ **Injury?** ☐Y ☐ N

History of Noise Exposure (e.g. power tools, firearms,): ☐Y ☐N **Hearing Protection?** ☐Y ☐N

If the test results indicated that a hearing aid would be helpful, are you ready to move forward with that today? _____

Medical History: ☐High Blood Pressure ☐Stroke ☐Head Injury ☐Cancer ☐ Arthritis ☐ Dementia ☐Kidney Disorder ☐ Autoimmune ☐Diabetes ☐ Heart Disease ☐ Tobacco Use

Referral Source: ☐ Insurance ☐ Doctor ☐ Word of Mouth ☐ Website ☐ Signage ☐ Mail/Flyer ☐ Google

16205 W 64th Ave Suite B3,Arvada, CO, 80007
303-424-3274 | Margaret@DrDenisonHearing.com