Colorado Hearing
Tinnitus and Balance

Patient Registration

Contact / Insurance Information

Patient Information

Name

Address

City State Zip Code

Contact Phone

Social Security Date of Birth

E-mail

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Emergency Contact (Spouse or significant other)

Name

Relation to Patient

Phone Number

Primary Insurance

Name

Policy Number

Phone Number

Secondary Insurance

Name

Policy Number

Phone Number

Medical Information

Primary Physician

Phone Fax

Drug Allergies

Current Medications

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General Health and Otologic (ear) History

Mark the following that apply (past and present)

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis
- ☐ Allergies
- ☐ Asthma
- ☐ Blood Disease
- ☐ Balance Issues
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy
- ☐ Dental
- ☐ Dizziness
- ☐ Diabetes type I
- ☐ Diabetes type II
- ☐ Endocrine Disease
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ GERD
- ☐ Glaucoma
- ☐ Growth / Lesion
- ☐ Hay Fever
- ☐ Heart Disease
- ☐ Head Injuries
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Indigestion
- ☐ IV antibodies
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorder
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problem
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Tinnitus
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sleep Disorders
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Swallowing Disorder
- ☐ Throat Issues
- ☐ Tuberculosis
- ☐ Thyroid Problems
- ☐ Ulcers
- ☐ Urinary

☐ Cancer _____

Please give additional details for anything marked above

_____

Do you have trouble hearing what others are saying ? ☐ Yes ☐ No

Do you have pressure or fullness ? ☐ Yes ☐ No

Do you have ear pain ? ☐ Yes ☐ No

Do you suspect any hearing loss? ☐ Yes ☐ No

If your problem is ear related, which ear is causing your problem? ☐ Right ☐ Left ☐ Both

If so, has it been ? ☐ Gradual ☐ Fluctuating ☐ Sudden

Do you hear a ringing, or noise, in your ear (Tinnitus)? ☐ Yes ☐ No If yes, please describe?

_____

Does anyone in your family have hearing loss? ☐ Yes ☐ No Who, and what kind?

_____

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General Health and Otologic (ear) History

(continued)

Do you hear ringing (tinnitus) or noise? ☐ Yes ☐ No If yes, please give details:

Do you have drainage from your ear(s) ? ☐ Yes ☐ No If yes, please give details:

Does dizziness, or loss of balance, come with your other symptoms ? ☐ Yes ☐ No If yes, please give details:

Have you had ear surgery ? ☐ Yes ☐ No If yes, please give details:

Have you had your hearing checked lately ? ☐ Yes ☐ No If yes, when and where:

Have you been exposed to loud noises, or explosions at time in your life ? ☐ Yes ☐ No If yes, when and where:

Have you been exposed to loud noises, or explosions within the past 24 hours ? ☐ Yes ☐ No

Do you know anything that may have caused your problem ? ☐ Yes ☐ No If yes, what:

Have you taken any of the following ? ☐ Streptomycin ☐ Gentamicin ☐ Quinine