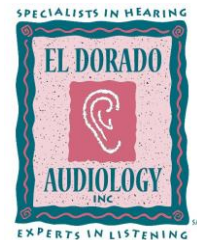


El Dorado Audiology  
6206 E Pima St, Suite 4  
Tucson, AZ 85712  
(520) 885-0234  
www.ElDoradoAudiology.com



Dear Patient,

Welcome to El Dorado Audiology. We are pleased that you have selected our office to serve you. Our goal is to provide the best understanding of your hearing healthcare needs and the most extensive personalized service.

**Please complete the enclosed forms and bring them with you to your appointment. This information is important for us to determine how we can best assist you. Please plan for approximately 1½ hours for your complete evaluation appointment.**

**We request that you bring someone close to you — or someone with whom you speak on a regular basis — to attend the appointment with you. This is not only beneficial for you, but it is extremely helpful for us to better understand how we can help you.**

When you come in for your initial evaluation, you can expect us to:

1. Review your history with you;
2. Perform a complete hearing evaluation; and
3. Explain your test results in detail.

If you have any questions prior to your appointment, please call us at 885-0234. We are looking forward to meeting you.

Sincerely,

A handwritten signature in cursive script that reads 'Carolyn Jaret'.

Carolyn Jaret, MS, CCC-A  
Owner, El Dorado Audiology



# 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: \_\_\_\_\_

## Primary Care Physician Information

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

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

Did your physician refer you to El Dorado Audiology? Yes No

Do you want a copy of your report mailed to your physician? Yes No

**I authorize a copy of my records to be sent to my physician**

\_\_\_\_\_  
Patient Signature Date

## 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

Seminar: \_\_\_\_\_

Health Fair: \_\_\_\_\_

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 NEEDS ASSESSMENT

Our goal is to best understand your communication needs, personal preferences, and expectations in order to recommend a hearing solution that is most appropriate for you. Below, please indicate how well you hear in the listed situations and how often you are in each of these situations. If you already wear hearing aids, please answer how well you hear when wearing your current hearing aids.

| Listening Situations    | How well do you hear in this situation? |      |      |      | How often are you in this situation? |           |       |
|-------------------------|---|------|------|------|--------------------------------------|-----------|-------|
|                         | N/A                                     | Poor | Fair | Good | Rarely                               | Sometimes | Often |
| Quiet Room (1-2 people) |   |      |      |      |                                      |           |       |
| Meetings/Lectures       |   |      |      |      |                                      |           |       |
| Religious Services      |   |      |      |      |                                      |           |       |
| Large Social Gathering  |   |      |      |      |                                      |           |       |
| Restaurants             |   |      |      |      |                                      |           |       |
| Theatre/Movies          |   |      |      |      |                                      |           |       |
| Television              |   |      |      |      |                                      |           |       |
| Telephone (landline)    |   |      |      |      |                                      |           |       |
| Cell Phone              |   |      |      |      |                                      |           |       |
| Outdoors                |   |      |      |      |                                      |           |       |
| In the Car              |   |      |      |      |                                      |           |       |
| Listening to Music      |   |      |      |      |                                      |           |       |
| Other:                  |   |      |      |      |                                      |           |       |

List the top 3 situations where you would most like to hear better:

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Do you have any concerns about wearing hearing aids?

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Is there anything else you would like us to know?

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**PLEASE NOTE:** Per the Health Insurance Portability and Accountability Act of 1996 (HIPPA), the NOTICE OF PRIVACY PRACTICES FOR EL DORADO AUDIOLOGY is posted in our lobby and available upon request.