PATIENT INFORMATION

NAME:_____________________________________ DATE:___________________

MAILING ADDRESS:____

____

HOME PHONE:_____________________________ CELL PHONE:______________________

DATE OF BIRTH:_____________________ SPOUSE'S NAME:_________________________

E-MAIL ADDRESS:____

PRIMARY CARE DOCTOR:____

HISTORY OF MAJOR ILLNESS OR ALLERGY:_______________________________________

____

Specifically: _____Diabetes _____Heart Disease _____ Stroke_____ History of Bleeding _____ Other_______________

If a **Medical Physician** must provide a written referral for your appointment today and the referral is not received by Audiology Specialists, LLC by the time of the appointment, you may be responsible for the full expense of the services provided.

I also agree to pay any charges if my Insurance Carrier denies coverage.

I also agree to pay a **$50.00** fee for any appointment I miss and fail to cancel within 24 hours of that appointment.

I understand this Policy and agree to pay any charges that I have incurred.

I request that payment of authorized Insurance Carrier benefits be made on my behalf to Audiology Specialists, LLC for any services furnished to me. I authorize the holder of medical information about me to release to the Health Care Financing Administration (HCFA) and its Agents any information needed to determine these benefits or the benefits payable for related services. By signing below, you authorize the release of any information required by your Insurance Carrier for payment of benefits.

____ ___________________________________

Patient/Guardian Signature **Print Name**

PATIENT NAME:____ DATE:________________________

Do you (or a blood relative) have any:

1. Blurring of vision? You_______ Family Member _________
2. Wear Glasses? You_________ Family Member____________
3. Numb fingers or strange sensations in your limbs? You __________ Family Member __________
4. Sensation of numbness, tingling or heavy feeling on your face? You___________ Family Member_________
5. Diabetes? You_______________ Family Member_____________
   Was onset: Childhood__________ Adult____________? Type_____________________
6. Kidney Problems? You_________ Family Member______________
7. More than one color of the eyes? You____________ Family Member______________
8. Unusual/unique outer shape ear? You _____________ Family Member______________
9. Unusual/unique skeletal (bone) features? You ____________ Family Member___________
10. History of easily broken bones? You ________________ Family Member______________
11. Heart trouble or heart disease? You_______________ Family Member________________
12. Premature graying of the hair? You ____________ Family Member _________________
13. History of headaches? You_______________ Family Member____________________
14. History of sinus trouble confirmed by sinus x-rays? You____________ Family Member_________

Have you ever used a hearing aid in the past? ____________________

a. Which ear? Right______________ Left________________ Both__________________
b. How long have you used hearing aids?____
c. How long have you had your present hearing aids?_______________________________________
d. What do you like about your hearing aids?____
   ____
e. What do you dislike about your hearing aids?____
   ____

What do you want to learn from your visit today?____

____

____

Do you use tobacco?_______ If so do you: Smoke:______ Chew Tobacco:_______

ADULT HISTORY QUESTIONNAIRE

PATIENT NAME:____ DATE:_______________________

What concern brought you here? (Please indicate below)

Hearing Loss________ Balance Trouble______ Ear/Head Noises__________ Other:_________________________

How were you referred to this Office?____

If you have hearing difficulty, please check all of the following that apply:

________Trouble hearing when in groups or noisy places

________Trouble hearing over the telephone

Which ear do you use on the telephone?__________________

________Trouble hearing at work? In what situations?____

________Trouble hearing a person talking from a distance of more than 6 feet

Which ear hears better_________________

How/When did you first notice your hearing loss?____

Did your hearing loss come on suddenly_____________or gradually________________

Have you ever had ear surgery?____________ If yes, please describe:_____________________________________

____

Do you ever hear a humming or buzzing sound in your head or ear(s)?______________________

If yes, please mark the following:

a. How often do you hear it? Constantly___________Comes and Goes_________At Night________________
b. Where do you hear it? Right ear___________ Left ear_________ Both ears___________ In head_______
c. What does it sound like?____
d. When did you first become aware of it?____
e. Can you associate it with an event or a change in medication?____________________________________
   If yes, please describe:____

Do any blood relatives have any hearing trouble? Yes_______ No_______ Don't Know__________

a. Please describe who:____
b. Please describe their hearing loss:____

Have you been exposed to loud noise due to work, hobbies or military service?______________

If yes, please describe:____

Do you have trouble with your balance?______________________

a. If yes, please describe:____
b. Does anyone in your family have this trouble?____
c. Do you ever feel "woozy" or "off" after making a particular movement or being in a particular position?
   _______ Please describe:____
d. Do you have trouble with your gait (walking)?_______ Does anyone in your family?____________

Patient Name:____ **Date:**_____________________

DESMOND FALL RIS-K QUESTIONNAIRE – Please circle your answer for each question.

1. Have you had a fall or near fall in the past year? **YES / NO**
2. Do you have a fear of falling that restricts your activity? **YES / NO**
3. Do you experience dizziness or a sensation of spinning when you lie down, tilt your head back or roll over in bed? **YES / NO**
4. Do you feel uneasy or unsteady when walking down the aisle of a supermarket or in an area congested with other people? **YES / NO**
5. Do your feet or toes frequently feel unusually hot, cold, numb or tingly? **YES / NO**
6. Do you wear bifocal or trifocal glasses, or is your vision noticeably better in one eye? **YES / NO**
7. Do you experience loss of balance or a lightheaded/faint feeling when you stand up? **YES / NO**
8. Do you take medication for depression, anxiety, nerves, sleep or pain? **YES / NO**
9. Do you take four or more prescription medications daily? **YES / NO**
10. Do you feel like your feet just won't go where you want them to go? **YES / NO**
11. Do you feel like you can't walk a straight line, or are pulled to the side when walking? **YES / NO**
12. Has it been longer than 6 months since you participated in regular exercise? **YES / NO**
13. Do you feel that no one really understands how much dizziness and balance problems affect the quality of life? **YES / NO**
14. Are you interested in improving your balance and mobility? **YES / NO**

Where Do You Experience Hearing Challenges?

To help us provide you with the best possible care, please take a few moments to complete the following questions. Your response will help us make your hearing evaluation and fitting appointment more efficient, effective and successful.

Please read the following statements. Beside each statement, make a check mark that best describes your experience in each situation.

NAME:____ **DATE:**________________________

	Always	Sometimes	Never
1. I have to ask people to repeat themselves even when I am in a quiet conversation with one or two other people.	______	_________	_______
2. My family members complain that I need to turn the television volume up louder than they do.	______	_________	________
3. When I talk on the telephone, I miss some of what is said.	______	_________	________
4. During a card game, or around a table, I have difficulty hearing the conversation.	______	_________	________
5. When I am in a busy public place (shopping center), I have difficulty communicating with others.	______	__________	________
6. In meetings, I have to strain to make sure I hear everything.	______	__________	________
7. When I am eating in a restaurant, I have to ask my dining companion to repeat things.	______	__________	________
8. I miss a lot of information during lectures.	______	__________	________
9. When I am listening to music/concerts, I miss parts of the words.	______	__________	________
10. If I am in the car with others who are talking, I can't hear what they are saying.	______	__________	________

Circle the numbers of the three listening situations/environments in which you experience the most difficulty hearing and would like to experience improvement.

If not listed please describe here:____

Your Name:____

Your Current Medications as of:______________________________

Please include **ALL** medications. This means prescriptions, over the counter, herbs, vitamins, minerals or dietary/nutritional supplements. Please list both those that you take routinely and those that you take only when needed.

DRUG NAME:	DOSAGE:	HOW OFTEN:	HOW TAKEN:

Patient Name____ Date:____________________

PATIENT HEALTH QUESTIONNAIRE - 9
(PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems: (Please check all that apply)	Not at all	Several days	More than half the days	Nearly every day
1. Little Interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have received a copy of Audiology Specialists, LLC's Notice of Privacy Practices. This Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be posted in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available.

____ ____________________

Printed Name of patient or personal representative ***Date***

____ ____________________

Signature of patient or personal representative ***Date***