AUDIOLOGY ASSOCIATES

hear today, hear tomorrow

Patient Name:			DOB:	
Address:				
City:			State:	Zip:
Phone:	Cell:		Email:	
Emergency Contact:			Phone:	
Relationship:			Marital Status:	☐Single ☐Married ☐Divorced ☐Widowed
Do you live in a Skilled Nursing, Assisted Living Facility, or Rehab Center? If yes, Name:_____Phone:_____				☐YES ☐NO
Employment Status:	☐Full-Time	☐Part-Time	☐Retired	☐Not Employed
Employer:			Occupation:	
Referring Physician:			Phone:	
Address:				
City:			State:	Zip:
Primary Care Physician: (If different from Referring)			Phone:	
Please state briefly the nature of your problem:				

Consent for Treatment

The patient/legal guardian authorizes Audiology Associates staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

☐**I understand that I am ultimately responsible for the balance on my account for any professional services rendered.** I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this claim. I authorize payment of medical benefits to the undersigned physician or supplier for services described.

Patient Signature:_____Date:_____

Printed Name:_____

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Please Check Any of the Following You Have Had or Currently Have:

☐Heart Disease	☐Tuberculosis	☐Artificial Joints	☐Diabetes	☐Cancer	☐Ringing in Ears
☐Pacemaker	☐Breathing Problems	☐Back Problems	☐Stroke	☐Depression	☐Infection/Wounds
☐Circulation Problem	☐ Emphysema/COPD	☐Neck Problems	☐Parkinson's	☐Nausea	☐Blood Disorders
☐High Blood Pressure	☐Asthma	☐Arthritis	☐Epilepsy/Seizures	☐Ulcer Disease	☐Glaucoma
☐Other:					

CURRENT SYMPTOMS

Which of the following best describes your symptoms?

☐Imbalance ☐Nausea ☐Falling more often

☐Lightheadedness ☐World spinning around you ☐Other:_____

☐Feel as if YOU are spinning; the world is not spinning

How long do your symptoms last without stopping?

☐Seconds ☐Minutes ☐Hours ☐Days ☐Symptoms are Constant

How many times per ☐day/☐week/☐month/☐year (check one) do you have an episode?_____

Did any of the following occur prior to your symptom onset? (check all that apply)

☐Head Trauma ☐Virus/Infection ☐Motor Vehicle Accident ☐Surgery

☐Change in Medication ☐Stressful Event/High Stress ☐A Fall ☐Other:_____

Have your symptoms ☐Improved/☐Changed/☐Stayed the Same (check one) since they began?

If Improved or Changed, how so:_____

Does anything make your symptoms better? ☐YES ☐NO

If Yes, what:_____

YES	NO	BALANCE & FALL SYMPTOMS (Check One)
☐	☐	Have you fallen in the past year? If yes, how many time:_____ If no, have you experience "near falls" but you caught yourself? ☐YES ☐NO
☐	☐	Are you afraid of falling?
☐	☐	Are you veering/leaning while walking? If yes, which direction? ☐RIGHT ☐LEFT ☐BOTH
☐	☐	Do you have neuropathy, numbness, or tingling in your feet or legs?
☐	☐	Has your exercise decreased?
☐	☐	Orthopedic injuries? If yes, what?_____

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YES	NO	DIZZINESS SYMPTOMS
☐	☐	Do you have a history of migraines?
		If yes, when was your most recent migraine?_____

Do any of the following trigger your symptoms? (check all that apply)

☐Increased stress ☐Skipping a meal ☐Changes in weather

☐Not drinking enough water ☐Certain foods:_____

Do any of the following accompany or occur immediately prior to an episode of your symptoms? (check all that apply)

☐Headaches

☐Neck Pain

☐Hearing Loss: ☐Right ☐Left ☐Both Ears

☐Fullness in your ear(s): ☐Right ☐Left ☐Both Ears

☐Ringing in your ear(s): ☐Right ☐Left ☐Both Ears

☐Shimmers or Sparkles in your Vision

☐Sensitivity to Light ☐Sound ☐Smell (check all that apply)

YES	NO	Check Yes or No for each of the following?
☐	☐	My dizziness is intense but only last for seconds or minutes
☐	☐	I get dizzy when I turn over in bed
☐	☐	I get short-lasting, spinning dizziness that happens when I bend down to pick something up
☐	☐	I get short-lasting, spinning dizziness that happens when I go from sitting to lying down
☐	☐	I can trigger my dizzy spells when I place my head in certain positions
☐	☐	I have had a single severe spell of spinning dizziness that lasted for hours to a day
☐	☐	After my big episode of dizziness, I could not walk for days without falling over
☐	☐	I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu
☐	☐	I had hearing loss in one ear at the same time I had the long episode of spinning dizziness
☐	☐	I have spells where I get dizzy, and it is difficult for me to breathe
☐	☐	I feel dizzy all the time
☐	☐	I am anxious most of the time
☐	☐	I am bothered by patterns, screens, e.g., supermarkets
☐	☐	My symptoms increase when I go from laying to sitting to standing
☐	☐	When I cough or sneeze, I get dizzy
☐	☐	I get dizzy when I strain to lift something heavy
☐	☐	When I speak, my voice sounds abnormally loud to me
☐	☐	My dizziness is provoked with head movements (up/down and/or right/left)
☐	☐	My head is heavy like a bowling ball
☐	☐	I have a headache that is in or starts in the back of my head
☐	☐	When I sit up from lying down, or stand up from sitting, I experience a few seconds of dizziness

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YES	NO	MEDICAL HISTORY
☐	☐	Are your blood sugar, blood pressure, and thyroid levels well controlled?
☐	☐	Do you have any known eye/vision issues? If yes, please explain:_____
☐	☐	Do you have hearing loss? If yes, which ear? ☐RIGHT ☐LEFT ☐BOTH EARS If yes, was it sudden? ☐YES ☐NO
☐	☐	Do you currently wear hearing aids?
☐	☐	I am experiencing ☐Ear Pain/☐Ringing/☐Drainage/☐Fullness (check all that apply) If yes, which ear? ☐RIGHT ☐LEFT ☐BOTH EARS

YES	NO	**IF APPLICABLE: FEMALE HORMONAL HISTORY
☐	☐	Have you had a hysterectomy? If yes, when?_____
☐	☐	Have you had any changes to your contraceptives? If yes, when?_____
☐	☐	Do you have a known hormonal imbalance? If yes, are you being treated for this issue? ☐YES ☐NO