

AUDIOLOGY ASSOCIATES

hear today, hear tomorrow

Patient Name:		DOB:	
Address:			
City:		State:	Zip:
Phone:	Cell:	Email:	
Emergency Contact:		Phone:	
Relationship:		Marital Status:	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed
Do you live in a Skilled Nursing, Assisted Living Facility, or Rehab Center? If yes, Name: _____ Phone: _____			<input type="checkbox"/> YES <input type="checkbox"/> NO
Employment Status:	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Retired <input type="checkbox"/> 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:			

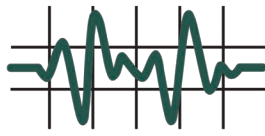
Consent for Treatment

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:

- | | | | | | |
|--|---|--|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Ringing in Ears |
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | <input type="checkbox"/> Infection/Wounds |
| <input type="checkbox"/> Circulation Problem | <input type="checkbox"/> Emphysema/COPD | <input type="checkbox"/> Neck Problems | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> Nausea | <input type="checkbox"/> Blood Disorders |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Ulcer Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> Other: _____ | | | | | |

CURRENT SYMPTOMS

Which of the following best describes your symptoms?

- | | | |
|---|--|---|
| <input type="checkbox"/> Imbalance | <input type="checkbox"/> Nausea | <input type="checkbox"/> Falling more often |
| <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> World spinning around you | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> 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?

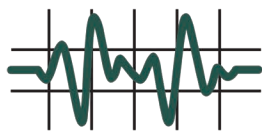
If Improved or Changed, how so: _____

Does anything make your symptoms better? YES NO

If Yes, what: _____

BALANCE & FALL SYMPTOMS (Check One)

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you fallen in the past year?
If yes, how many time: _____ |
| | | If no, have you experience "near falls" but you caught yourself? <input type="checkbox"/> YES <input type="checkbox"/> NO |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you afraid of falling? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you veering/leaning while walking?
If yes, which direction? <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have neuropathy, numbness, or tingling in your feet or legs? |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your exercise decreased? |
| <input type="checkbox"/> | <input type="checkbox"/> | Orthopedic injuries? If yes, what? _____ |

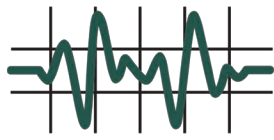


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YES	NO	DIZZINESS SYMPTOMS
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a history of migraines? If yes, when was your most recent migraine? _____
Do any of the following trigger your symptoms? (check all that apply)		
<input type="checkbox"/> Increased stress <input type="checkbox"/> Skipping a meal <input type="checkbox"/> Changes in weather		
<input type="checkbox"/> Not drinking enough water <input type="checkbox"/> Certain foods: _____		
Do any of the following accompany or occur immediately prior to an episode of your symptoms? (check all that apply)		
<input type="checkbox"/> Headaches		
<input type="checkbox"/> Neck Pain		
<input type="checkbox"/> Hearing Loss: <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Ears		
<input type="checkbox"/> Fullness in your ear(s): <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Ears		
<input type="checkbox"/> Ringing in your ear(s): <input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both Ears		
<input type="checkbox"/> Shimmers or Sparkles in your Vision		
<input type="checkbox"/> Sensitivity to Light <input type="checkbox"/> Sound <input type="checkbox"/> Smell (check all that apply)		

YES	NO	Check Yes or No for each of the following?
<input type="checkbox"/>	<input type="checkbox"/>	My dizziness is intense but only last for seconds or minutes
<input type="checkbox"/>	<input type="checkbox"/>	I get dizzy when I turn over in bed
<input type="checkbox"/>	<input type="checkbox"/>	I get short-lasting, spinning dizziness that happens when I bend down to pick something up
<input type="checkbox"/>	<input type="checkbox"/>	I get short-lasting, spinning dizziness that happens when I go from sitting to lying down
<input type="checkbox"/>	<input type="checkbox"/>	I can trigger my dizzy spells when I place my head in certain positions
<input type="checkbox"/>	<input type="checkbox"/>	I have had a single severe spell of spinning dizziness that lasted for hours to a day
<input type="checkbox"/>	<input type="checkbox"/>	After my big episode of dizziness, I could not walk for days without falling over
<input type="checkbox"/>	<input type="checkbox"/>	I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu
<input type="checkbox"/>	<input type="checkbox"/>	I had hearing loss in one ear at the same time I had the long episode of spinning dizziness
<input type="checkbox"/>	<input type="checkbox"/>	I have spells where I get dizzy, and it is difficult for me to breathe
<input type="checkbox"/>	<input type="checkbox"/>	I feel dizzy all the time
<input type="checkbox"/>	<input type="checkbox"/>	I am anxious most of the time
<input type="checkbox"/>	<input type="checkbox"/>	I am bothered by patterns, screens, e.g., supermarkets
<input type="checkbox"/>	<input type="checkbox"/>	My symptoms increase when I go from laying to sitting to standing
<input type="checkbox"/>	<input type="checkbox"/>	When I cough or sneeze, I get dizzy
<input type="checkbox"/>	<input type="checkbox"/>	I get dizzy when I strain to lift something heavy
<input type="checkbox"/>	<input type="checkbox"/>	When I speak, my voice sounds abnormally loud to me
<input type="checkbox"/>	<input type="checkbox"/>	My dizziness is provoked with head movements (up/down and/or right/left)
<input type="checkbox"/>	<input type="checkbox"/>	My head is heavy like a bowling ball
<input type="checkbox"/>	<input type="checkbox"/>	I have a headache that is in or starts in the back of my head
<input type="checkbox"/>	<input type="checkbox"/>	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
<input type="checkbox"/>	<input type="checkbox"/>	Are your blood sugar, blood pressure, and thyroid levels well controlled?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any known eye/vision issues? If yes, please explain: _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have hearing loss? If yes, which ear? <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH EARS If yes, was it sudden? <input type="checkbox"/> YES <input type="checkbox"/> NO
<input type="checkbox"/>	<input type="checkbox"/>	Do you currently wear hearing aids?
<input type="checkbox"/>	<input type="checkbox"/>	I am experiencing <input type="checkbox"/> Ear Pain/ <input type="checkbox"/> Ringing/ <input type="checkbox"/> Drainage/ <input type="checkbox"/> Fullness (check all that apply) If yes, which ear? <input type="checkbox"/> RIGHT <input type="checkbox"/> LEFT <input type="checkbox"/> BOTH EARS

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