Animas Valley Audiology

ADULT CASE HISTORY

Patient Name: _____ Date: _____

Chief complaint: (mark all that apply)

❑ Hearing Loss ❑ Cerumen/Wax ❑ Tinnitus/Ringing ❑ Vertigo/Dizziness

1. How long have you noticed the above condition(s)? _____
2. What do you attribute it to? _____
3. How did this progress? ❑ Gradually ❑ Suddenly
4. Have you ever been exposed to loud sounds, either recently or in the past? ❑ No
   ❑ Yes If so, please mark all that apply:
   ❑ Farm Equipment ❑ Music/iPod ❑ Hunting/Shooting ❑ Work-Related Noise: _____
   ❑ Power Tools ❑ Armed Forces ❑ Motorcycles ❑ Other: _____
5. Do you currently wear a hearing protection device (HPD) in the presence of loud sounds? ❑ No ❑ Yes
   I use: ❑ Ear Muffs ❑ Foam Earplugs ❑ Musician earplugs ❑ Custom-made
   Are you interested in discussing custom-fit hearing protection today? ❑ No ❑ Yes
6. Have you had any of the following? (mark all that apply)
   ❑ Deformity of the ear ❑ Drainage of the ear ❑ Head Trauma ❑ Ear pain
   ❑ Sudden or rapid loss within the past 90 days ❑ Acute or chronic dizziness ❑ Tinnitus(ringing)
7. Have you ever had your hearing tested? ❑ No ❑ Yes If so, when was your last test? _____
8. Is there a history of hearing loss in your family? ❑ No ❑ Yes If so, who? _____
9. Have you ever had an ear infection? ❑ No ❑ Yes (If yes, ❑ as a child ❑ as an adult)
10. Have you ever had ear-related surgery? ❑ No ❑ Yes If so, type, when, where? _____
11. Do you take any prescription medications on a regular basis? If so, please list medication and related condition:
    Medication: _____ Dose and Strength: _____
    Medication: _____ Dose and Strength: _____
12. Are you a current tobacco user? ❑ No ❑ Yes If yes, are you interested in quitting: ❑ No ❑ Yes
13. Have you had 2 or more falls in the past 12 months? ❑ No ❑ Yes If yes, did your fall(s) result in injury? ❑ No ❑ Yes
14. Please check any of the following that you currently have or have had in the past:
    ❑ Arthritis ❑ Heart Condition ❑ Measles ❑ Parkinson
    ❑ Asthma ❑ Hepatitis ❑ Meniere's Disease ❑ Scarlet Fever
    ❑ Bell's Palsy ❑ High Blood Pressure ❑ Meningitis ❑ Sinusitis
    ❑ Diabetes (type?_____) ❑ HIV or AIDS ❑ Mumps ❑ Stroke/TIA
    ❑ Head Injury ❑ Malaria ❑ Neurological Disorder ❑ Vision Loss
15. Do you currently utilize hearing aids? ❑ No ❑ Yes
    If yes, when did you purchase them? _____ How many hours/day do you wear them? _____
    Do you have any complaints with your current aids? (explain) _____
16. Why have you decided to have your hearing tested at this time? (mark all that apply)
    ❑ Annual Evaluation ❑ Physician Referral ❑ Family/Friend Referral _____
    ❑ Healthy Curiosity ❑ I feel my hearing is poor and may need to be aided.
17. Please rank the following in order of importance if hearing aids are recommended for you: (1-4, 1 being the most important)
    ____ Overall Sound Quality ____Reliability ____Style/Appearance
    ____Expense

_____ _____

Signature Date

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ADULT PATIENT REGISTRATION FORM

First_____Middle Int____Last_____Prefer to be called _____
Date of Birth_____ Age_____Gender_____Social Security #_____-_____-_____
Address (Mailing) _____
Physical Address (If different than mailing)_____
Home # _____ Work #_____ Cell #_____
Personal email address:_____
Employer:_____ Occupation:_____
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed
Significant Other's Name (if applicable)_____
Emergency Contact (name & relationship)_____Phone #_____
Referred by _____
Primary Care Physician_____
How did you hear about Animas Valley Audiology Associates? (Please check one):
❑ Referred by Physician ❑ Mailer ❑ Online ❑ Referred by Friend _____
❑ Directory Plus (red book) ❑ Dex (yellow book) ❑ Newspaper Ad (paper_____) ❑ Other _____

Insurance Information ~ Please provide receptionist with card(s) to copy (all insurance information is required at the time of service)

Primary Insurance Company_____Card Holder's Name _____
ID#_____Group ID#_____Card Holder's Social Security# _____
Cardholder's Date of Birth_____Card Holder's Relationship to the Patient _____
Primary Cardholder's Employer _____
Address of Cardholder if Different from Patient _____
Secondary Insurance Company_____ID# _____

Consents and Written Acknowledgments (please initial and sign below)

I,_____, authorize and request my insurance company to be billed by Animas Valley Audiology Associates and pay all medical benefits due under the provision of my policy to this practice. I authorize release of medical information requested by my insurance company to process claims. I understand that I am ultimately responsible for all expenses incurred for services provided regardless of my insurance status. I consent to evaluation by Animas Valley Audiology Associates for audiology evaluations and treatment. _____
(initial)

I authorize Animas Valley Audiology Associates to release copies of tests and audiology reports to:
❑ Primary Care Physician listed above ❑ ENT listed above ❑ Other:_____

I,_____, acknowledge that a copy of Animas Valley Audiology Associates' Notice of Privacy Practices is available for review; I do not want a copy of it.
OR
I,_____, acknowledge that a copy of Animas Valley Audiology Associates' Notice of Privacy Practices is available for review; I have received a copy of it.

Signature:_____ Date: _____

Animas Valley Audiology

Patient Hearing Questionnaire

Name: _____

We would like to ask you a few questions to better understand your listening lifestyle and how we might improve your quality of life.

Does a hearing problem...	Always	Sometimes	Never
Cause you to have to ask people to repeat themselves?	A	S	N
Cause you to have difficulty hearing when in the presence of background noise?	A	S	N
Cause you to have difficulty hearing women's or children's voices?	A	S	N
Cause you to have difficulty following conversations in a restaurant?	A	S	N
Cause you to turn up the television or radio?	A	S	N
Cause you to hear people speak but fail to understand what they are saying?	A	S	N
Hinder ease of conversation during outdoor activities?	A	S	N
Cause you to feel as though others mumble?	A	S	N
Make it difficult for you to converse on a landline telephone?	A	S	N
Make it difficult for you to converse on a cell phone?	A	S	N
Limit or hamper your personal or social life?	A	S	N
Cause you to feel stressed or tired when listening for long periods of time?	A	S	N
Create difficulity while riding with others in the car?	A	S	N

Please select your current and (if different) desired lifestyle

☐ Active Lifestyle (Frequent background noise) ☐ Casual Lifestyle (Occasional background noise)

☐ Quiet Lifestyle (limited background noise) ☐ Very Quiet Lifestyle (Rare background noise)

Please provide the top three listening situations where you would like to hear better.

1. _____
2. _____
3. _____

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Companion Questionnaire

Name: _____ Name Of Patient: _____
Relation to Patient:_____
We would like to ask you a few questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

Does a hearing problem...	Always	Sometimes	Never
Make it difficult for your companion to converse on the telephone?	A	S	N
Cause you to complain that your companion turns up the television or radio too loud?	A	S	N
Cause your companion to have difficulty following conversations in a restaurant?	A	S	N
Limit or hamper your companion's personal or social life?	A	S	N
Cause your companion to have to ask people to repeat themselves?	A	S	N
Cause your companion to have difficulty hearing when in the presence of background noise?	A	S	N
Cause your companion to have difficulty hearing women's or children's voices?	A	S	N
Hinder ease of conversation during outdoor activities?	A	S	N
Cause your companion to hear people speak but fail to understand what they are saying?	A	S	N
Cause your companion to feel as though others mumble?	A	S	N
Create difficulity while riding together in the car?	A	S	N
Cause your companion to feel stressed or tired when listening for long periods of time?	A	S	N

Please select your companion's current and (if different) desired lifestyle

☐ Active Lifestyle (Frequent background noise) ☐ Casual Lifestyle (Occasional background noise)

☐ Quiet Lifestyle CTimited background noise) ☐ Very Quiet Lifestyle (Rare background noise)

Please provide the top three listening situations where you would like your companion to hear better.

1. _____
2. _____
3. _____