# COLORADO SPRINGS AUDIOLOGY, INC.

1330 West Colorado Avenue, Colorado Springs, CO 80904, Phone: 719-520-1155 Fax: 7190-520-0130

## CASE HISTORY FOR ADULT AUDIOLOGY EVALUATION

Until further notice, upon entering our building, wear a facemask properly covering your nose and mouth, even if you have been vaccinated. Reception room seating is properly distanced with adequate ventilation. We do our part to keep you safe so please do *your* part until 90% of the US population is COVID-19 immune.

Please answer: Have you HAD, or have you ever tested POSITIVE for COVID-19 disease? Yes No

**Patient Information** Date_________________

*Person completing this form if not the patient along with relationship to patient*____________________________________

Patient's Name _____________________________________________ Birthdate _________ Age ____ Gender _______
LAST FIRST MI NICKNAME

Address ________________________________________________ Phone Number ___________________________
STREET CITY STATE ZIP

Who referred you? ______________________________ Physician and/or NP _________________________________

Reason for visit: __ Check hearing __ Known hearing loss ___ Ringing in the ears ___ Other _____________________

## HEARING

Do you have a hearing problem? __ Yes __ No. If *NO*, skip to Tinnitus and Balance. If yes, please answer the following:
Was the onset of your hearing loss: ___ Sudden or ___ Gradual (i.e., develop over time)
Which ear do you think is worse? ___ Right ear ___ Left ear ___ Unsure Are you deaf in either ear? __ Yes __ No

***BECAUSE OF YOUR HEARING PROBLEM (this is a self-assessment – answer either "yes" "no" or "sometimes")***

| | | | |
|---|---|---|---|
| Do you ever feel embarrassed when meeting new people? | Yes | No | Sometimes |
| Do you ever feel frustrated when talking to family members? | Yes | No | Sometimes |
| Do you have difficulty when someone speaks in a whisper? | Yes | No | Sometimes |
| Do you feel "handicapped" or disable? | Yes | No | Sometimes |
| Are you less likely to attend church due to hearing loss? | Yes | No | Sometimes |
| Do you ever have family arguments? | Yes | No | Sometimes |
| Do you have difficulty understanding friends and family? | Yes | No | Sometimes |
| Do you have difficulty listening to T.V. programs? | Yes | No | Sometimes |
| Is your personal or social life restricted in any way? | Yes | No | Sometimes |
| Do you have trouble hearing in restaurant? | Yes | No | Sometimes |

Have you ever had your hearing tested before? Yes No

If yes, when and where (if you remember)?_____________________________________________________________

If you remember, what were you told? __________________________________________________________________

## TINNITUS AND BALANCE

**Tinnitus:** Do you experience ear noises such as ringing or buzzing in your ears? Yes No

If yes, describe what it most sounds like: __ Ringing ___ Hissing __ Buzzing __ Humming __ Insects __ Roaring

**Balance:** Do you experience severe problems with your balance? Yes No

If yes, describe what it feels like: __ Light-headedness ___ Unsteadiness __ A tendency to fall ___ Spinning

If yes, how long does your dizziness last? ___ It is constant ___ A few seconds ___ A few hours

## EARWAX ISSUES

Do you have problems with earwax? Yes No If "yes", which ear(s): Right ear Left ear Both ears Unsure
If yes, what symptoms, if any are you experiencing? ________________________________________________

## FAMILY HISTORY OF HEARING LOSS

Please check any relatives who developed hearing loss prior to age 40: Or circle NA

| | | | |
|---|---|---|---|
| ___ Mother | ___ Father | ___ Grandfather (s) | ___ Grandmother(s) |
| ___ Brother(s) | ___ Sister(s) | ___ Aunt (s) | ___ Uncles(s) |
| ___ Cousins | ___ Nephew(s) | ___ Nieces(s) | ___ Other |

## GENERAL MEDICAL HISTORY

Please check if you have ever had or currently have any of the following medical conditions?

| | | | |
|---|---|---|---|
| ___ COVID-19 | ___ Type II Diabetes | ___ Type I Diabetes | ___ Cancer(s) |
| ___ Kidney problems | ___ Liver problems | ___ Diabetes | ___ Genetic disorder |
| ___ Arthritis | ___ Sinus problems | ___ High blood pressure | ___ Breathing problems |
| ___ Heart problems | ___ Allergies | ___ Head injuries | ___ Limited dexterity |
| ___ Bleeding problems | ___ Stroke | ___ HIV/AIDS | ___ Other |

## MEDICAL EAR HISTORY

Please check all of the following that apply to you:

Had many ear infections as a child
Currently experiencing frequent ear infections
Have had one or more ear surgeries
Currently have drainage from one or both ear(s)

If you checked any of the above, please explain: ________________________________________________
________________________________________________________________________________

## NOISE HISTORY

Please check all of the following that apply to you:

Military service
Factory noise
Construction work
Farming
Hunting/firearms
Musician
Pilot
Airline industry employment
Other

If you checked any of the above, please explain: ________________________________________________

## HEARING AID HISTORY

Do you currently have or use hearing aids? Yes No

If so, do you use them? Yes No

If so, did they go over your ear, or were they custom in the ear? __ Over the ear (BTE) __ Custom in the ear

If so, how long have you had them? ______________________________

If so, where did you get them? ______________________________

## HIPAA STATEMENT

The **Health Insurance Portability and Accountability Act of 1996, Pub. L. 104-191 ("HIPAA")** describes how your medical information may be used and disclosed and how you can get access to this information. Your protected health information may be used and disclosed by your healthcare professional(s), our office staff, and others outside this office that are involved in your healthcare and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the audiologist's practice, and any other use required by law. With your permission, we will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your healthcare with a third party.

Do you understand and agree with our HIPAA policy? Yes No

## FINANCIAL INFORMATION

Unless authorized, payment for services is private pay. Please be aware that while you may be Medicare eligible, Medicare will not pay for hearing aids, nor will Medicare pay for any tests associated with the purchase of hearing aids.

Do you understand and agree with our FINANCIAL policy? Yes No

## AUTHORIZATION FOR PROVIDE SERVICES

With your signature below, you permit Dr. McHugh and staff to render services. Dr. McHugh is a clinical audiologist, not a physician (medical doctor). Audiologists are the professionals trained to best evaluate your hearing and hearing aids needs.
Audiologists possess a minimum Master's degree in audiology and some also have doctoral degrees within their area of expertise. If you would prefer to see a physician to rule out a medical problem before trying hearing aids, we will refer you to your family physician.

________________________________________ ____________________________

Signature of patient or guardian Today's date

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