COLORADO SPRINGS AUDIOLOGY, INC.

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CASE HISTORY FOR ADULT AUDIOLOGY EXAMINATION

Patient Information Date____________________

Person completing this form ☐ *Self* ☐ *Other* *(relationship to patient)* ____

Patient's Name ____ SS#__________________
LAST FIRST MI NICKNAME

Birthdate _____/_____/___________ Age ________ Gender: ☐ Male ☐ Female Marital Status: ☐S ☐M ☐D ☐W
MONTH DAY YEAR

Address ____
STREET CITY STATE ZIP

Phone ____
HOME BUSINESS CELL EMAIL

Occupation: ☐Working ☐Retired ☐N/A____
JOB TITLE EMPLOYER

☐ If self-referred, how did you learn about our office: ☐Web site ☐TV ☐Yellow pages ☐ Other____________________

☐ Who referred you? _________________________☐MD/DO ☐ Friend ☐ Family ☐Patient ☐Other________________

Family Physician ________________________ Address ________________________________ Phone __________

Reason for being seen is ____

- I experience one or more of the following: ☐ Hearing loss ☐ Ringing in ears ☐ Dizziness ☐ Fullness in ears
- Onset of my problem was: ☐Sudden ☐Gradual ☐Very gradual ☐Other____________________________________
- What do you think caused your problem? ☐ Age ☐ Noise exposure ☐ Previous ear disease ☐ Other
- If other, please explain ____
- Is there a family history of hearing loss? ☐Yes ☐No If so, who? ☐ Mother ☐Father ☐Brother(s) ☐Sister(s) ☐ Grandfather ☐ Grandmother ☐Aunt ☐Uncle ☐ Other____
- Have you worked around loud noise ☐Yes ☐No If so, what kind of noise: ☐ Military ☐ Factory ☐ Construction ☐ Firearms ☐ Music ☐ Airline ☐ Other ____
- Which ear is worse? ☐ Right ear ☐ Left ear ☐Unsure
- Is there a past history of medical ear problems or surgeries: ☐Yes ☐No_________________________________
- Have you ever used hearing aids before: ☐Yes ☐No If so, what kind? ___________________________________
- Do you currently have hearing aids? ☐Yes ☐No ☐ Right ear ☐ Left ear ☐ Both ears
  - If so, what kind? __________________
  - How old are they? ___________________
  - Where were they purchased? _____________________

Are you taking any anti-coagulants such as Coumadin or Warfarin to control a risk of stroke? ☐ Yes ☐ No
Are you allergic to latex? ☐ Yes ☐ No

Past Medical Histories: ☐ High blood pressure ☐Arthritis ☐Kidney problems ☐Heart problems ☐Liver problems ☐Senile dementia ☐Alzheimers ☐Stroke ☐Allergies ☐ Sinus problems ☐ HIV or AIDS ☐Hepatitis (type C) ☐Mental disorders ☐Head trauma ☐Diabetes ☐Bleeding problems ☐Tremors ☐Use Oxygen ☐Dexterity problems (with hand or fingers) ☐Parkinson's Thyroid ☐Genetic disorders ☐ Cancer ☐Vision problems

Other health issues____

To rule out potentially serious medical conditions requiring immediate referral to your family physician or medical specialist, please list any sudden and dramatic changes within the past 90 days:

- ☐ Single-sided hearing loss (unilateral deafness)
- ☐ Severe vertigo
- ☐ Loud or painful ringing in the ears
- ☐ Severe ear pain
- ☐ Bleeding or other discharge from the ear(s)
- ☐ Significant fullness/pressure in the either ear

Medications:

Drug Name	Reason for use
___________________________	____
___________________________	____
___________________________	____
___________________________	____

BECAUSE OF A HEARING PROBLEM:

• I feel embarrassed when meeting new people	☐Yes	☐No	☐Sometimes
• I get frustrated when talking to family members	☐Yes	☐No	☐Sometimes
• I have difficulty when someone speaks in a whisper	☐Yes	☐No	☐Sometimes
• I feel "handicapped" or disabled	☐Yes	☐No	☐Sometimes
• I am less likely to attend church or social events	☐Yes	☐No	☐Sometimes
• I have gotten into family arguments	☐Yes	☐No	☐Sometimes
• I have difficulty understanding friends and family	☐Yes	☐No	☐Sometimes
• I have difficulty listening to T.V. programs	☐Yes	☐No	☐Sometimes
• It has restricted my personal or social life.	☐Yes	☐No	☐Sometimes
• I have trouble hearing in restaurant	☐Yes	☐No	☐Sometimes

HHIE = ________

PLEASE READ AND SIGN BELOW:

Authorization to render services: With your signature below, you permit Dr. McHugh and staff to render services. Dr. McHugh is a clinical audiologist, NOT a medical doctor. Audiologists are professionals qualified to evaluate your hearing and hearing aids needs. Audiologists possess a minimum Master's degree in audiology and some 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, please contact your primary care physician.

HIPPA Statement: With your signature below, you permit Dr. McHugh and staff to communicate your protected health information with your physician and others outside this office that are involved in your health care and treatment for the purpose of providing health care services to you, including when necessary payment of your health care bills. This is to support the operation of our practice and any other use as allowed by HIPPA law.

Financial Awareness and Consent: Unless arranged, payment is expected at the time of service. If hearing aids are needed or prescribed, please note that most insurances *including Medicare* do not cover hearing aids nor do any supplemental insurances to Medicare. If you would like to submit your services to your insurance, we will provide you with a Super-bill that you may use to submit to your own health insurance.

Preference of payment: ☐ Cash ☐Check ☐Credit Card (We accept, MC Discover and VISA)

☐ I have read and agree with the Authorization to provide services, HIPPA statement and financial obligations

Patient signature ____________________________________ Date ____________

Responsible Party's Signature ____________________________________ Date _____________