COLORADO SPRINGS AUDIOLOGY, INC.

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HISTORY FOR ADULT AUDIOLOGY EXAMINATION

Date_____

Please Print

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

Patient's Name _____ _____ _____ _____ **Birthdate** _____
LAST FIRST MI NICKNAME MONTH / DAY / YEAR

Age _____ **Gender** ☐Male ☐Female **Marital Status** ☐Single ☐Married ☐Divorced ☐Widow

Patient's Address _____
STREET CITY STATE ZIP

Contacts _____
HOME PHONE (Landline) CELL PHONE BUSINESSPHONE EMAIL

Employment Status ☐NA ☐Retired ☐Employed at _____
BUSINESS NAME PHONE EMAIL

How did you learn about our office? ☐Friend ☐Physician ☐Web site ☐TV ☐Phone book ☐Other_____

Physician's Name_____ Have you seen a medical ear specialist before? ☐Yes ☐No

If "yes" who did you see and what was it for? _____

Reason for being seen today: ☐Hearing problem ☐Ringing in ears ☐Dizziness ☐Fullness in ears ☐Other

_____

IF YOU CHECKED HEARING PROBLEMS, PLEASE COMPLETE THE FOLOWING

- Onset hearing problem was: ☐Sudden ☐Gradual ☐Other_____
- Which ear is worse? ☐Right ear ☐Left ear ☐Unsure
- What do *YOU* think caused your problem? ☐Age ☐Noise ☐Previous ear disease ☐Don't know ☐Other
- If "other" please explain _____
- Is there family history of hearing loss? ☐Yes ☐No If so, who? _____
- Have you worked around loud noise? ☐Yes ☐No, If "Yes" what kind of noise: ☐Military ☐Factory ☐Construction ☐Power Tools ☐Firearms ☐Music ☐Airline ☐Other _____
- 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? _____

Check if you have or have had any of the following: ☐Allergies ☐Sinus problems ☐High blood pressure ☐ Arthritis ☐Kidney problems ☐Heart problems ☐Type I diabetes ☐Type II diabetes ☐Bleeding problems ☐Tremors ☐Vision problems ☐Walking problems ☐Breathing Problems (If so, do you use oxygen? ☐Yes ☐No) ☐ ☐Dexterity problems ☐Parkinson's ☐Thyroid ☐Genetic disorders ☐Cancer ☐Stroke ☐HIV or AIDS ☐Hepatitis) ☐Mental disorders ☐Head trauma ☐Senile dementia ☐Alzheimer's Disease ☐Other _____

***Within past 90 days* check if you have, or have had:** ☐Sudden deafness ☐Sudden onset of ear pain ☐Severe vertigo ☐Bleeding or other discharge from the ear(s) ☐Sudden onset of loud or painful ringing in the ears

Are you taking anti-coagulant medication to control a risk of stroke? ☐Yes ☐No **Allergic to latex?** ☐Yes ☐No

IF YOU HAVE HEARING PROBLEMS, HOW DOES YOUR HEARING LOSS MAKE YOU FEEL?

- 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 restaurants ☐Yes ☐No ☐Sometimes

PLEASE CHECK BELOW EACH STATEMENT 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 aid 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.

☐ I authorize Colorado Springs Audiology to render services

☐ I do not authorize Colorado Springs Audiology to render services

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.

☐ I have read and understand your HIPPA statement

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.

☐ *If applicable*, I understand the financial awareness and consent

Patient Signature _____ Date _____

Responsible Party's Signature _____ Date _____