

# 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 \_\_\_\_\_