ASSOCIATED AUDIOLOGISTS, INC – PATIENT HISTORY

Patient Name:___________________________________ **DOB:** __________ **Date:**______________

Primary Concern(s): ____

____

How or when did your problem first occur?____

Have any of these concerns been previously evaluated? __________________________________

If so, where/when: __________________________________ **Occupation:** ______________________

I. Please check any of the following that you currently have or have had in the past:

☐ Family history of hearing loss
☐ Vision Loss
☐ Peripheral Neuropathy
☐ Diabetes
☐ High Blood Pressure
☐ Heart Condition
☐ Measles and Mumps
☐ Meningitis
☐ Migraines
☐ Ear Infections
☐ Meniere's disease
☐ Sinusitis
☐ CMV
☐ Head Injury: Date of Injury ______________________
☐ HIV or AIDS
☐ Hepatitis
☐ Multiple Sclerosis
☐ Bell's Palsy: Affected Side ______________________
☐ Parkinson's Disease
☐ Stroke/TIA: Affected Side _______________________
☐ Neurological Disorders__________________________
☐ Ear Trauma: Type _____________________________
☐ Ear Surgery: Type _____________________________
☐ Tingling/numbness in face
☐ MRI or CT-Scan of head: Date _______ Location ___________
☐ Other ____________________________

II. Do you have any of the following symptoms? If applicable, please indicate which ear.

☐ Difficulty Hearing	Left Ear	Right Ear	Both
☐ Ear Pain	Left Ear	Right Ear	Both
☐ Ear Drainage	Left Ear	Right Ear	Both
☐ Ear Fullness/Pressure	Left Ear	Right Ear	Both
☐ Noise in your ears/head (tinnitus)	Left Ear	Right Ear	Both

Describe Sound ____

III. Questions about hearing loss. If you do <u>not</u> experience hearing loss, please skip this section and proceed to section IV.

☐ Difficulty in Quiet Environments
☐ Difficulty in Noisy Environments
☐ Trouble understanding television
☐ Trouble understanding on the telephone
☐ Hearing loss began suddenly
☐ Hearing loss has progressed gradually
☐ Fluctuations in your hearing

IV. Questions about tinnitus (ringing/noises in your ears/head). If you do <u>not</u> experience tinnitus, please skip this section and proceed to section V.

Yes	No	
☐	☐	Did your tinnitus begin suddenly?
☐	☐	Did any specific incident precipitate the onset of your tinnitus? ______________________
☐	☐	Does anything make your tinnitus better? ____
☐	☐	Does anything make your tinnitus worse? ____
☐	☐	Is your tinnitus constant?

- Continued on Back -

V. Questions about dizziness/vertigo and imbalance. If you do not experience these symptoms, please skip this section and proceed to section VI.

Yes	No	
☐	☐	Do you have dizziness/vertigo?
☐	☐	Does anything provoke your dizziness/vertigo? ___________________________________
☐	☐	Is your dizziness/vertigo constant?
☐	☐	Are you off balance?
☐	☐	Have you experienced falls?
☐	☐	Do you have a fear of falling?
☐	☐	Do you currently use an assistive device?

VI. Do you have a history of exposure to loud noise? Yes No Hearing Protection: Yes No

If yes, please describe: ____

VII. Please list all medication you are currently taking, attach an additional page if needed.

Medication: _______________________ **For:** __________________________ **Since:** ____________

Medication: _______________________ **For:** __________________________ **Since:** ____________

Medication: _______________________ **For:** __________________________ **Since:** ____________

Medication: _______________________ **For:** __________________________ **Since:** ____________

VIII. List 3 areas, in order of importance, you want to improve regarding your hearing, tinnitus or dizziness/balance.

1 - ____

2 - ____

3 - ____

Hearing Aid Preferences

If results show that hearing aids would be beneficial, are you ready to try amplification?
Please rate your readiness on this 1-10 scale.

Not Ready 1 2 3 4 5 6 7 8 9 10 Absolutely Ready

Please rank these factors in order of importance (1 being most important, 4 being least important):

____ Hearing in Quiet ____ Hearing in Noise ____ Hearing Aid Expense ____ Cosmetics

FOR CURRENT HEARING AID USERS ONLY

Do you wear 1 hearing aid or two?_____ How long have you worn hearing aid(s)?_____________

Make/Model________________________ How old are your present hearing aid(s)?_____________

How often do you wear your hearing aid(s)?____

What would you want to improve about your current hearing aids?______________________________

ASSOCIATED AUDIOLOGISTS, INC.

NOTICE OF RESPONSIBILITY

Associated Audiologists, Inc. is a participating provider for the following insurance programs:

Advantra
Aetna (Diagnostic Only)
Blue Cross/Blue Shield of KC & KS (all products)
Champus/Tri-Care
Cigna Healthcare (all products)
Coventry Healthcare
United HealthCare (Diagnostic Only)
Healthcare Preferred
Medicare
Humana (all products)
Kansas Medicaid
Freedom Network
Health Access

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING:

I understand that if my insurance is not listed above, I need to make payment, in full, at the time of service. Associated Audiologists, Inc will file my insurance claim for me; however, this does not guarantee that my insurance will pay in full, and I will be responsible for payment of any remaining balance due.

I understand that if my insurance policy lists a required co-payment, I am to pay this at the time of service.

If any of the above listed insurance companies do not cover the full allowed amount of services rendered, I understand that it is my responsibility to pay any remaining balance due.

Most insurance companies do not offer benefits for the purchase of hearing aids; however, there are a few that do have hearing aid benefits. I understand that it is my responsibility to find out whether or not my insurance policy offers benefits for hearing aids. **If it is determined that my insurance does offer benefits for hearing aids, I understand that it is my responsibility to notify Associated Audiologists, Inc. PRIOR to the ordering of my hearing aids(s).**

Associated Audiologists, Inc accepts payment by cash, personal check, money order/cashiers checks, Mastercard and Visa. If other arrangements are necessary, I will discuss them with the office staff before I am seen by the audiologists.

I HAVE READ, UNDERSTAND, AND AGREE TO THE ABOVE STATEMENT:

______________________________ ______________

Patient/Guardian Signature Date

2/2006

WELCOME TO ASSOCIATED AUDIOLOGISTS, INC.

Name:_______________________________________ Date of Birth:_____/_____/_____ Age:______
First MI Last Social Security #_______/_____/_________
Address:____
Street Apt # City State Zip
Home Telephone:_______________________ Employer Name:_______________________
Other Phone (mobile/other):_______________ Employer Telephone:___________________
E-Mail Address:______________________
Do we have your permission to communicate with you via the above E-mail Address: ❑ Yes ❑ No

This information is required if your spouse is the primary policyholder of your insurance:
Spouse's Name:_______________________ Daytime Telephone:_____________________
Spouse's Employer:____________________ Date of Birth:_____/_____/_____
Spouse's Social Security #_______/_____/_____(only needed if spouse is insurance policyholder)

In case of emergency, please contact: Name:______________________Relationship:__________
Telephone Number:_______________________________

PLEASE COMPLETE THE FOLLOWING SECTION IF PATIENT IS A MINOR (under 18 years of age)

Father's Name_______________________
Social Security #_____/_____/__________
Date of Birth: _____/_____/_____
Home Phone (if different)______________
Work Phone_________________________
Employer:___________________________

Mother's Name:______________________
Social Security #_____/_____/__________
Date of Birth: _____/_____/_____
Home Phone (if different)______________
Work Phone_________________________
Employer:___________________________

Who is your primary care physician? ____________________________**Phone:**______________
(If you would like a copy of your test results forwarded to your physician, please sign the release below)

Who referred you to our office?

We would like to know how our patient's find our practice. If your physician, a family member, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful if we know that too. Please check below the MOST influential sources of information about this practice. If it is your physician, an audiologist, family member, or a friend, please provide their name. Thank You!

_____Physician _____Vocational Rehabilitation _____Health Plan/HMO
_____Audiologist _____Yellow Pages _____Attended Seminar
_____Family Member _____Newspaper Ad/Article _____Internet
_____Friend/Co-worker _____Hospital Referral Service _____Other:__________

Please provide the name of the person that referred you to our office:___________________________

In order for us to file your insurance claim for you, the following MUST be signed:

I authorize the release of any medical and/or other information necessary to process my medical claim. I also request payment of government benefits, either to myself or to the party who accepts assignment.

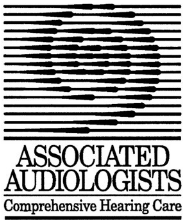
Further, I authorize payment of medical benefits to be made directly to ASSOCIATED AUDIOLOGISTS, INC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____________________________________ _____/_____/_____
Patient/Parent/Guardian Signature Date

RELEASE OF MEDICAL INFORMATION

I, _______________________, hereby authorize Associated Audiologists, Inc. to release any and all medical information in the course of my (or my child's) treatment to the primary care physician listed above. I would also like to have this information forwarded to:_____________________________________

_____________________________________ _____/_____/_____
Patient/Parent/Guardian Signature Date



Vestibular and Equilibrium
New Patient Instructions and Information

Patient Instructions

You will be instructed to refrain from taking certain medications for 48 hours prior to your appointment. There are certain medications that can influence or interfere with your test results, thus resulting in inaccurate or misleading information. If you have any concern with the discontinuation of any of the medications listed below, please consult with your prescribing physician.

Alcohol: beer, wine, cough medicine

Analgesics – Narcotics: Codeine, Demerol, Phenaphen, Tylenol with codeine, Percocet, Darvocet

Anti-Histamines: Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin, and any over-the-counter cold remedy

Anti-Seizure Medications: Dilantin, Tegretol, Phenobarbital

Anti-Vertigo Medications: Antivert, Ru-vert, Meclizine

Anti-Nausea Medications: Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergen, Thorazine, Scopolamine, Transdermal

Sedatives: Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill

Tranquilizers: Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanex

YOU MAY TAKE BLOOD PRESSURE, HEART, AND THYROID MEDICATIONS, TYLENOL, INSULIN, ESTROGEN, ETC. ALWAYS CONSULT YOUR PHYSICIAN BEFORE DISCONTINUING ANY PRESCRIBED MEDICATION.

Please eat lightly for 12 hours prior to your appointment. If your appointment is in the morning, you may have a light breakfast (such as juice and toast). If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch. *Please avoid caffeine in beverages such as coffee or soft drinks.*

PLEASE DO NOT WEAR EYE MAKEUP (MASCARA, EYE SHADOW, ETC.)

Testing may cause a very slight sensation of motion, which lingers after your evaluation. If possible, we encourage you to have someone accompany you to and from the appointment. If this is not possible, please schedule an additional 15 to 30 minutes after your test, so you may wait for the sensation to clear before leaving our office.

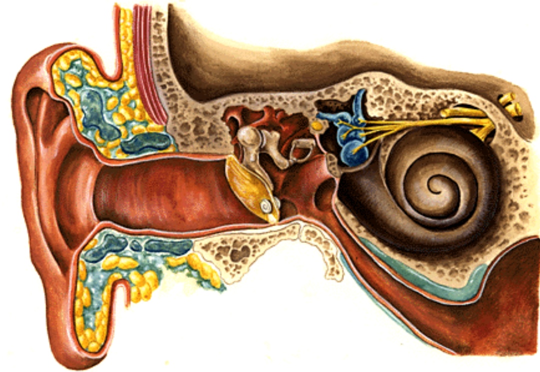
Patient Information

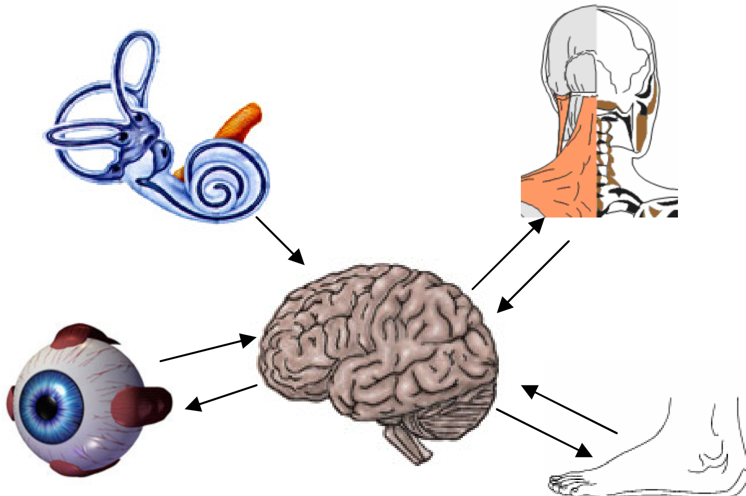
A comprehensive battery of tests will be performed during your evaluation. As your evaluation will be thorough, testing will take approximately 2 hours. Prior to each test, a detailed explanation will be given to you, so you gain a better understanding of what we are measuring and what to expect.

Evaluating and Treating Equilibrium Disorders:
Problems with the equilibrium system can result in dizziness, vertigo, and imbalance. The equilibrium system is very complex and cannot be directly observed. To truly understand a patient's equilibrium, a number of sophisticated tests must be performed, correlated, and compared.

-Evaluation-

Balance disorders are often accompanied by changes in hearing and/or ear function. These changes can be acute and hardly noticeable by the patient. Your testing will include comprehensive testing of your outer, middle, and inner ears. These tests include: *audiologic, immittance, and Otoacoustic emission* tests.

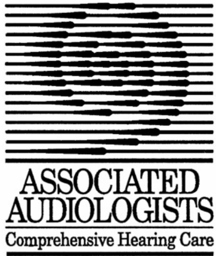




There are a number of complex pathways that control our equilibrium. Your evaluation will include sophisticated measures of these pathways and your central nervous system. These tests are: *Vestibular Evoked Myogenic Potential, Auditory Brainstem Response, Vestibular Auto-Rotation, Dynamic Visual Acuity, Electro-oculography, Sensory Organization Performance, and Video/Electro-nystagmography*

-Treatment-

There are a number of well researched, successful, and widely used treatments and management strategies for problems of the equilibrium system. These treatments address such issues as vertigo, dizziness, lightheadedness, and balance problems. All forms of treatment should certainly be preceded by a comprehensive evaluation and diagnosis; this ensures that the specific treatment chosen is appropriate for you.



Associated Audiologists, Inc.
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Shawnee Mission, KS 66204
913-403-0018
www.hearingyourbest.com

PATIENT QUESTIONNAIRE

PATIENT NAME: ____ **DATE:** ____________________

Patients with equilibrium disorders may experience a wide variety of symptoms. These symptoms may include issues ranging from dizziness, vertigo, and lightheadedness to imbalance, unsteadiness, and falls. Please answer the questions below to the best of your ability. Some of the questions may not be applicable or easy to answer, but please respond as accurately as possible.

How or when did your problem first occur? ____

How long did it last? ____

I. Please read each of the following questions carefully and indicate your response with an 'X' in either the first box for YES or the second box for NO.

YES	NO	
☐	☐	Do you experience motion sickness, air sickness, or sea sickness?
☐	☐	Did you experience motion sickness as a child?
☐	☐	Do you have a family history of motion sickness?
☐	☐	Do you experience migraines?
☐	☐	Have you ever been exposed to solvents, chemicals, etc.?
☐	☐	Have you experienced an injury to the head? When?________________________________
☐	☐	Have you lost consciousness because of an injury to the head?
☐	☐	Have you had a neck or back injury?
☐	☐	Do you take any medications regularly? If yes, What? ____ ____ ____
☐	☐	Do you use alcohol? How many drinks/week?____ How often?______ Most recent?__________
☐	☐	Do you smoke? How much? ____
☐	☐	Are you diabetic? __________________ Is your blood pressure high/low? __________________

II. The next section will ask specific questions about your balance. If you do not experience issues with your balance, please skip this section and proceed to section III.

YES	NO	
☐	☐	Are you off balance?
☐	☐	Do you have difficulty walking?
☐	☐	Do you have a fear of falling?
☐	☐	Have you fallen? If yes, How many times? _____ When was most recent? ________________________ Where? _____________________ Inside home? _________ Outside home? _________
☐	☐	Do you have a loss of balance when walking? If yes, do you veer to either the right or left? ____________________________________
☐	☐	Do you have trouble walking in the dark?
☐	☐	Do you currently or have you ever used an assistive device (cane, walker, etc)?
☐	☐	Have you ever received therapy for your balance? If yes, When? _____________ Where? __________________________________

(continued)

III. The next section will ask specific questions about dizziness/vertigo. If you do not experience dizziness or vertigo, please skip this section and proceed to section IV.

YES	NO	
☐	☐	Is your dizziness constant? If you answered yes, please go to section IV.
☐	☐	Does your dizziness occur in attacks? If yes, how often? ____________________
☐	☐	Are you completely free of dizziness between attacks?
☐	☐	Do you have any warning that the attack is about to start? If yes, what? ____________________
☐	☐	Is the dizziness provoked by a specific head/body movement? If yes, what direction? ____________________
☐	☐	Is the dizziness better or worse at any particular time of the day? If yes, when? ____________________
☐	☐	Do you know of anything that will stop your dizziness of make it better? If yes, what? ____________________
☐	☐	Do you know of anything that will make your dizziness worse? If yes, what? ____________________
☐	☐	Do you know of anything that will precipitate an attack? If yes, what? ____________________
☐	☐	Do you know of any possible cause of your dizziness? If yes, what? ____________________

IV. Do you currently experience any of the following sensations? Please read the entire list and check the boxes that most accurately describe your experience. You may check as many boxes as needed.

YES	NO	
☐	☐	Lightheadedness
☐	☐	A swimming sensation in the head
☐	☐	A sensation that you could black out or lose consciousness
☐	☐	Objects are spinning or turning around you
☐	☐	An internal spinning sensation, with objects around you remaining stationary
☐	☐	Nausea or vomiting
☐	☐	Pressure in the head

V. Have you ever experienced any of the following sensations? If yes, please check the appropriate box and circle either "constant" or "in episodes."

YES	NO			
☐	☐	Double vision?	Constant	In Episodes
☐	☐	Blurred vision or blindness?	Constant	In Episodes
☐	☐	Spots before your eyes?	Constant	In Episodes
☐	☐	Numbness in face, arms, or legs?	Constant	In Episodes
☐	☐	Weakness in arms or legs?	Constant	In Episodes
☐	☐	Confusion or loss of consciousness?	Constant	In Episodes
☐	☐	Difficulty swallowing?	Constant	In Episodes
☐	☐	Tingling in the face or around the mouth?	Constant	In Episodes
☐	☐	Difficulty speaking?	Constant	In Episodes

VI. Do you have any of the following symptoms? Please indicate which ear is involved.

YES	NO				
☐	☐	Difficulty hearing? If yes, when did this start? ____________________	Left Ear	Right Ear	Both
☐	☐	Does your hearing change with your other symptoms?	Left Ear	Right Ear	Both
☐	☐	Noise in your ears or head? If yes, does the noise change with your symptoms? ____________________	Left Ear	Right Ear	Both
☐	☐	Fullness, pressure, or stuffiness in your ears?	Left Ear	Right Ear	Both
☐	☐	Pain in your ears?	Left Ear	Right Ear	Both
☐	☐	Discharge from your ears?	Left Ear	Right Ear	Both
☐	☐	Have you ever had surgery on your ears?	Left Ear	Right Ear	Both
☐	☐	Have you had your hearing evaluated? If yes, When? ____________________ By whom? ____________________			