PENN AUDIOLOGY

Hearing & Balance Professionals

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Age: _____
First MI Last

Address: _____
Street Apt # City State Zip code

Phone #: _____ Phone #: _____
Primary Circle one: Cell/Work/Home Secondary Circle one: Cell/Work/Home

Email:_____

EMPLOYER INFORMATION

Employer: _____ Employer Phone #: _____

Emergency Contact: _____
Name Phone Number Relationship

Spouse Information: (Required if your spouse is the primary insurance policy holder)

Spouse Name: _____ Primary Phone #: _____

Spouse Employer: _____ Date of Birth: _____

Who referred you to our office? CIRCLE ONE

Physician	Internet
Family	Mailing
Friend	Health Insurance
Hospital Referral	Newspaper/Magazine
Attended Seminar	Other: _____

Please specify the name of the referral: ___ _____

Please complete if patient is under the age of 18 years old

Father's Name: _____ Mother's Name: _____

Date of Birth: _____ Date of Birth: _____

Primary Phone #: _____ Primary Phone #:_____

Employer: _____ Employer: _____

Release of Medical Information

Primary Care Physician: _____
Name City Phone

Referring Physician: _____
Name City Phone

Other Person/Organization: _____

I, _____, hereby authorize Penn Audiology Hearing & Balance Professionals to release any and all medical information in the course of my (or my child's) medical care to the physician (s), person or organization listed above.

_____ _____
Signature of Patient, Parent, or Guardian Date

Please sign the following so we file your insurance claim:

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 Penn Audiology Hearing & Balance Professionals for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

_____ _____
Signature of Patient, Parent, or Guardian Date

PENN AUDIOLOGY
Hearing & Balance Professionals

Acknowledgement of Receipt of Notice of Privacy Practices Health Insurance Portability & Accountability Act (HIPAA)

Acknowledgement

I acknowledge that I have received, reviewed and understand, the Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that I will be offered a copy of any amended Notices of Privacy Practices at each appointment.

By law, we are only authorized to communicate directly, with the patient regarding any form: of protected health information which Includes scheduled appointments, insurance information, hearing aid Information.

Please check below:

_____ I give Penn Audiology - Hearing and Balance Professionals authorization to communicate with my: immediate family, or persons which I specified below regarding my private health care information.

1. _____

2. _____

_____ I do not authorize Penn Audiology – Hearing & Balance Professionals to speak with anyone regarding my private health care.

_____ Permission to leave a message on your home answering machine: Yes _____ No _____

Please contact Penn Audiology - Hearing and Balance Professionals if you do not wish to receive educational or marketing information and materials.

_____ _____

Patient or Personal Representatives Signature Date

If personal representative signature above, please indicate the relationship to the patient.

_____

(Relationship to Patient)

PENN AUDIOLOGY
Hearing & Balance Professionals

HEALTH HISTORY QUESTIONNAIRE

Patient Name:	DOB:	DATE:
Primary Concern:		

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR CURRENTLY HAVE:

Hearing:
- ☐ Hearing loss
- ☐ Family History of Hearing loss

Tinnitus:
- ☐ Ringing in ears
- ☐ Sound Sensitivity

Vestibular:
- ☐ Dizziness/vertigo ☐
- ☐ Imbalance/Falls

Ear:
- ☐ Ear Pain
- ☐ Fullness/pressure
- ☐ Drainage
- ☐ Ear Trauma
- ☐ Ear Drum Perforation
- ☐ Infections
- ☐ Surgery
- ☐ Skin Lesions on the Ear
- ☐ Rashes or Spots on the Ear
- ☐ Cholesteotoma

Nose/Throat:
- ☐ Congestion
- ☐ Sinusitis
- ☐ Allergies

Previous Diagnosis:
- ☐ Meniere's Disease ☐
- ☐ Labrynthitis

Neurological:
- ☐ Peripheral Neuropathy
- ☐ Facial Numbness or Tingling
- ☐ Numbness in Hands or Feet
- ☐ Headaches / Migraines
- ☐ Tremors
- ☐ Head Injury
- ☐ Bell's Palsy
- ☐ Multiple Sclerosis
- ☐ Parkinson's Disease
- ☐ Alzheimer's Disease
- ☐ Stroke/TIA

Endocrine:
- ☐ Diabetes
- ☐ Thyroid Disorder

Musculoskeletal:
- ☐ Decreased range of motion
- ☐ Decreased fine motor skills
- ☐ Extremities Pain
- ☐ Back or Neck Pain
- ☐ Back or Neck Surgery
- ☐ Arthritis

Cardiovascular:
- ☐ Pacemaker
- ☐ High/Low Blood Pressure
- ☐ Fainting
- ☐ Lightheadedness
- ☐ Cardiovascular Surgery

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Memory Loss ☐
- ☐ Cognitive Changes

Eyes:
- ☐ Vision Loss
- ☐ Blindness

Other:
- ☐ Measles
- ☐ Mumps
- ☐ Meningitis
- ☐ Scarlet Fever
- ☐ Lyme Disease
- ☐ Syphilis
- ☐ Herpes
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Cytomegalovirus (CMV)
- ☐ Mononucleosis (Mono)
- ☐ Shingles/Chicken Pox
- ☐ Cancer
- ☐ Auto-Immune Disorder
- ☐ Tuberculosis (TB)
- ☐ Kidney Disease

Other-
_____
_____
_____

Please list location and date:

Hearing Evaluation: _____
Vestibular Evaluation: _____
MRI or CT scan: _____
Tinnitus Evaluation: _____
ENT Evaluation: _____

List Medications

Name	Reason	Start Date

Do you have a history of noise exposure? ☐ YES ☐ NO Explain: _____

Do you wear hearing protection during noise exposure? ☐ YES ☐ NO

Hearing:			
Difficulty hearing:	☐ Right Ear	☐ Left Ear	☐ Both Ears
More difficulty hearing in:	☐ Right Ear	☐ Left Ear	☐ Hearing is the same between ears
Hearing difficulties began:	☐ Suddenly	☐ Gradually	
When did you first notice hearing difficulties?			
Has it progressed?	☐ Yes	☐ No	

Tinnitus, ringing or noise in your ears/head				
Tinnitus exists in	☐ Right Ear	☐ Left Ear	☐ Both Ears	☐ Head
Do you hear tinnitus more in:	☐ Right Ear	☐ Left Ear	☐ Tinnitus is the same between ears	
Tinnitus began:	☐ Suddenly	☐ Gradually		
When did you first notice tinnitus?				
Has it progressed?	☐ Yes	☐ No		
Is your tinnitus bothersome?	☐ Yes	☐ No	☐ Sometimes	☐ I hear it but it does not bother me
Describe the sound you hear.				

Dizziness/Imbalance			
Do you have dizziness or imbalance?	☐ Yes	☐ No	☐ Sometimes
Describe your dizziness.			
Does anything trigger your dizziness/imbalance?			
Have you fallen in the past 12 months?			

What are the outcomes you would like to get out of this appointment? _____

_____

HEARING QUESTIONNAIRE

	Yes	No	Sometimes
1. Does a hearing problem cause you to feel embarrassed when you meet new people?			
2. Does a hearing problem cause you to feel frustrated when talking to members of your family?			
3. Do you have difficulty hearing when someone speaks in a whisper?			
4. Do you feel handicapped by a hearing problem?			
5. Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?			
6. Does a hearing problem cause you to attend religious services less often than you would like?			
7. Does a hearing problem cause you to have arguments with family members?			
8. Does a hearing problem cause you difficulty when listening to TV or radio?			
9. Do you feel that any difficulty with your hearing limits or hampers your personal or social life?			
10. Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

Of the following situations, choose up to 5, in order of significance, that you would like to improve:

A. Conversation with 1 or 2 in quiet
B. Conversation with 1 or 2 in noise
C. Conversation with group in quiet
D. Conversation with group in noise
E. Television/Radio at a normal volume
F. Familiar speaker of the phone
G. Unfamiliar speaker on the phone
H. Hearing phone ring from another room
I. Hearing front door bell or knock
J. Hear Traffic
K. Increased social interactions
L. Feel embarrassed or stupid
M. Feel left out
N. Feeling upset or angry
O. Church or meeting
P. Other (explain)

1. _____

2. _____

3. _____

4. _____

5. _____

PATIENT QUESTIONARE

What brought you to our office today? _____

_____

_____

What is your experience with hearing aids? *(check all that apply)*

- ◯ **I have never visited with an Audiologist to inquire about Hearing Aids.**
- ◯ **I have visited with an Audiologist to gather information regarding my hearing difficulties, but I have not tried or purchased.**
- ◯ **I have tried hearing aids but returned the instruments.**
- ◯ **I have hearing aids but only wear it occasionally or not at all.**
- ◯ **I have a hearing aid and wear it regularly on the** ◯ **left ear,** ◯ **right ear.**

Please rank the following in terms of their importance in a hearing aid. *(1 through 4, with 1 being the most important):*

◯ **Overall Sound Quality** ◯ **Reliability** ◯ **Style/Appearance** ◯ **Cost**

On a scale of 1-10, how motivated are you regarding doing something about your hearing loss? *(Please circle one)*

1 2	3 4	5 6	7 8	9 10
Not Motivated	Somewhat Motivated	Motivated	Very Motivated	Extremely Motivated