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 & 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 & 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

Vestibular and Equilibrium
New Patient Instructions and Information

You will be instructed to refrain from taking certain medications for 48 hours prior to your appointment. Certain medications can influence or interfere with your test results, which may lead to inaccurate findings. Please consult with your prescribing physician prior to stopping any medication. Also, please feel free to contact our office with any questions.

Alcohol: Beer, wine, cough medicine, etc.

Analgesics/Narcotics: Codeine, Demerol, Phenaphen, Tylenol w/ Codeine (Tylenol-3), Percocet, Darvocet.

Anti-Histamines: Chlor-Trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanal, Claritin, and any over-the-counter cold remedies.

Anti-Seizure Medications: Dilantin, Tegretol, phenobarbital.

Anti-Vertigo Medications: Antivert, Ru-Vert, meclizine.

Anti-Nausea Medications: Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, scopolamine transdermal.

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

Tranquilizers: Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanax.

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 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.

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: __________________________
Tinnitus Evaluation: ________________________
Vestibular Evaluation: _________________________
ENT Evaluation: ___________________________
MRI or CT scan: ______________________________

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:

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, 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

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? ______________________________________

____

PENN AUDIOLOGY
Hearing & Balance Professionals

VESTIBULAR 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 column for YES or the second column 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 left or the right?_________________________
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? _______________________________

PENN AUDIOLOGY
Hearing & Balance Professionals

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 no, 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 column that most accurately describes your experience. You may check as many 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 column 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

PENN AUDIOLOGY

Hearing & Balance Professionals

(continued)

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

YES	NO				
		Difficulty hearing?	Left Ear	Right Ear	Both
		If yes, when did this start? ______________________			
		Does your hearing change with your other symptoms?	Left Ear	Right Ear	Both
		Noise in your ears or head?	Left Ear	Right Ear	Both
		If yes, does the noise change with your symptoms? ______________________			
		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? _____________			

Dizziness Handicap Inventory

Name:________________________________DOB:______________Date:______________

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness or unsteadiness. Please answer "yes" (Y), "no" (N) or "sometimes" (S) to each question.

Answer each question as it applies to your dizziness or unsteadiness only.

Item	Question		Y	N	S
1	Does looking up increase your problem?	P			
2	Because of your problem, do you feel frustrated?	E			
3	Because of your problem, do you restrict your travel for business or recreation?	F			
4	Does walking down the aisle of a supermarket increase your problem?	P			
5	Because of your problem, do you have difficulty getting into or out of bed?	F			
6	Does your problem significantly restrict your participation in social activities such as going out to dinner, the movies, dancing or to parties?	F			
7	Because of your problem, do you have difficulty reading?	F			
8	Does performing more ambitious activities such as sports or dancing or household chores such as sweeping or putting dishes away increase your problem?	P			
9	Because of your problem, are you afraid to leave your home without having someone accompany you?	E			
10	Because of your problem, are you embarrassed in front of others?	E			
11	Do quick movements of your head increase your problem?	P			
12	Because of your problem, do you avoid heights?	F			
13	Does turning over in bed increase your problem?	P			
14	Because of your problem, is it difficult for you to do strenuous housework or yard work?	F			
15	Because of your problem, are you afraid people may think you are intoxicated?	E			
16	Because of your problem, is it difficult for you to walk by yourself?	F			
17	Does walking down a sidewalk increase your problem?	P			
18	Because of your problem, is it difficult for you to concentrate?	E			
19	Because of your problem, is it difficult for you to walk around the house in the dark?	F			
20	Because of your problem, are you afraid to stay at home alone?	E			
21	Because of your problem, do you feel handicapped?	E			
22	Has your problem placed stress on your relationship with members of your family or friends?	E			
23	Because of your problem, are you depressed?	E			
24	Does your problem interfere with your job or household responsibilities?	F			
25	Does bending over increase your problem?	P			
			x4	x0	x2

P__________________ E__________________ F__________________ Total_______________