Adult Audiology History

Dr. Brandy D. Vowell, AuD

Adult Audiology History Form

*******Please complete both pages and return to the front desk******

Name_____**Date of Birth**_____
(Last) (First) (Initial) (M/D/Y)

Mailing Address:_____

Apt. #_____**City:**_____ **State:**_____ **Zip:**_____

Occupation (past/present) _____ **Email address:**_____

Family Physician: _____

Home Telephone: _____ **Cell Phone:** _____ **Work**_____

*****Please circle your primary phone number you would like us to use to contact you*****

If you prefer a text message as an appointment reminder instead of a phone call please circle and initial next to the TEXT agreement. Standard text messaging rates will apply and are determined by your individual carrier and are your financial responsibility.

YES, Please TEXT appointment reminders to my cell phone provided above._____ (initial)

How did you hear about us?

Friend/Relative Billboard Tv Radio Physician Work Online Insurance Other:_____

What is the purpose of your hearing exam/office visit today? (Circle all that apply)

Baseline Hearing Exam	Hearing Protection/Custom Ear Plugs	Hearing Conservation Program
Military/VA Exam	Interested in Purchasing Hearing Aids	Wax removal/Aural hygiene
Bluetooth/Assistive Devices	Workers Comp	Other:_____

Will this be the first time you've had a hearing test? **YES** **NO**

If no, when were you last tested? _____

Have you ever had ear surgery? **YES** **NO**

If yes, then when? _____ Which ear:_____ Procedure:_____ ENT/Surgeon:_____

Do you have noises or ringing in your ears? **YES** **NO** **Left ear** **Right Ear** **BOTH ears**

Does the noise or ringing occur: **Occasionally** **Intermittent** **Constant**

Did you have chronic ear infections as a child or adult? **YES** **NO**

Do you have chronic ear pain? **Right ear** **Left ear** **Both ears** **YES** **NO**

Do you have acute or chronic ear drainage? **YES** **NO**

If YES: Right ear Left ear Type of treatment and by whom?_____

Have you ever been diagnosed or feel you have TMJ? **YES** **NO**

Do you have a family history of hearing loss? **YES** **NO**

Have you been exposed to a lot of noise in your life? **YES** **NO**

Type of noise: Occupational_____ Recreational/Hobbies_____ Music/Musician Military

Do you currently utilize hearing protection? **YES** **NO** **What type do you use?** **Generic fit foam type plugs** **Custom fit plugs**

Have you always used hearing protection with loud noise? **YES** **NO**

Are you interested in learning more about the various types of custom hearing protection products available? **YES** **NO**

Have you had any trauma to the head? **YES** **NO**

Cause: _____ When:_____

Do you have sinus or allergy problems? **YES** **NO**

If YES is it CONSTANT or SEASONAL **Have you been Allergy Tested?** **YES** **NO**

Have you ever had radiation therapy to the head or neck region **YES** **NO**

Please explain:

_____

Do you have a bleeding disorder/blood clotting disorder? **YES** **NO**

Do you currently take blood thinners of any kind? **YES** **NO**

Do you bruise, scratch, bleed easily, or take longer than normal time to heal? **YES** **NO**

Do you have controlled/uncontrolled or insulin dependent diabetes? **YES** **NO**

Do you have any type of implantable medical device? (Pacemaker, deep brain stimulator) **YES** **NO**
Do you have regular or frequent MRI testing? **YES** **NO**
Have you had chemotherapy in the last 6 months? **YES** **NO**
Have you been diagnosed with any cognitive or memory disease/disorders **YES** **NO**
Have you been diagnosed with Meniere's disease or other vestibular disorders? **YES** **NO**

When Diagnosed? _____ How often do you have attacks? _____

Other symptoms associated with attacks? (Hearing loss, tinnitus, headache):_____

Do you currently or have you ever smoked? **YES** **NO**
As a Child or Adult have you been exposed to excessive second hand smoke? **YES** **NO**

*****Please list or attach ALL MEDICATIONS you currently take and WHAT YOU TAKE THEM FOR*****

_____

_____

Please CIRCLE any of the following if applicable:

Heart disease Stroke Kidney disease Thyroid disorder Lung disease Learning Difficulties

Behavioral issues Cancer Meningitis Tick Borne Diseases Other_____

Do you feel your hearing loss has been gradual over time or sudden? _____

If sudden, what was date of onset? _____ Any other symptoms? _____

Do you have difficulty hearing in large or small groups? **YES** **NO**
Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors? **YES** **NO**
Does a hearing problem cause you to attend church/meetings/events less often? **YES** **NO**
Does a hearing problem cause you difficulty when listening to TV, telephone, or radio? **YES** **NO**
Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? **YES** **NO**
Do you have difficulty hearing women or children? **YES** **NO**

In which ear do you feel you hear better? **Left Ear** **Right Ear** **No Difference**

What do you believe caused your hearing problem? _____

Has family or friends suggested you have your hearing checked? **YES** **NO**

Do you currently wear hearing aids? **YES** **NO**

If yes, circle: Left Only Right Only Both Ears

What year and where did you buy your hearing aids? _____

How often do you wear your aids? _____Do you have any problems with your hearing aids?_____

Do your current hearing aids have Bluetooth?_____ What type of cell phone do you have?_____

What would you like to change about your current aids?_____

Why are you interested in new hearing aids?_____

Your insurance policy is a contract between you and your insurance company. We cannot guarantee payment of your claims or accept responsibility for negotiating claims with your insurance company. As a courtesy we will be happy to help you determine the coverage you have available. Signing below authorizes The Hearing Doctor/Brandy D. Vowell, AuD to have assigned benefits of all charges submitted and to receive payment directly from the insurance company, and acknowledges responsibility for payment of bill in full by insured if insurance does not cover 100% in a timely fashion. Patient is responsible for entire medical bill regardless of amount paid/allowed by insurance. I am aware that services not covered by my insurance may include the following: case history review, diagnosis and recommendations, counseling, wax removals, vestibular testing, tinnitus exams, hearing aid checks, OSHA/workers compensation reviews, and hearing protection. I hereby authorize The Hearing Doctor/Brandy D. Vowell, AuD to release all information necessary to secure payment from my insurance and to provide my family physician with results regarding my appointment as The Hearing Doctor/Brandy D. Vowell, AuD deems necessary.

Patient Name Print AND Sign: **Date:**