Patient Information Form

SPENCER AUDIOLOGY CLINIC

Patient Name _____ Date _____
First MI Last

Preferred Name _____ Date of Birth ___/___/_____ Age _____ Gender ◯ Female ◯ Male

Home Phone # _____ Cell Phone # _____

Work Phone # _____ Email _____

Mailing Address _____
Street City State Zip Code

How did you hear about us?

◯ Walk-in ◯ DVR ◯ Employer ◯ HLA ◯ Insurance ◯ Mail ◯ Newspaper Ad ◯ Senior Center ◯ Yellow Pages

◯ Lions Club ◯ Assisted Living Facility _____ ◯ Online _____ (website/search engine)

◯ Event _____ ◯ Family/Friend/Patient _____

◯ Physician/Facility _____ ◯ Other _____

Employment Status: ◯ Retired ◯ Full-time ◯ Part-time ◯ Unemployed ◯ Student

Occupation/Employer (if **RETIRED**): _____

Marital Status: ◯ Married ◯ Single ◯ Widowed ◯ Divorced ◯ Long-Term Commitment

Spouse/Partner Name _____ Emergency Contact _____

Phone # _____ Relation to Patient _____

Primary Care Physician and/or Facility _____

Insurance Information: Please let our front office staff know if you have insurance so that we can make a copy for our records.

Assignment and Release: Please read below carefully

I, the Patient or Guardian, certify that the information on this form is true to the best of my knowledge. I authorize Spencer Audiology Clinic to release any information necessary to process an insurance claim on my behalf. I also authorize my insurance benefits to be paid directly to Spencer Audiology Clinic and I understand that I am financially responsible for all charges whether or not paid by my insurance. I acknowledge that I have received and reviewed the Health Insurance Portability & Accountability Act (HIPAA) policy of this office.

I have read and understand the above information.

Patient Signature _____ Date _____

Legal Guardian Signature _____

HEARING HISTORY

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Name _____ Date _____

What kind of hearing problems do you have? (Describe specific situations of difficulty regarding your hearing)

_____

_____

When did your hearing loss begin? _____

What do you think caused your hearing loss? _____

_____

Do you hear better in one ear? _____ If so, which ear? _____

Was it a sudden hearing loss or a gradual decrease in hearing? Has your hearing worsened recently? _____

_____

Do you have problems hearing over the telephone? ◯ Yes ◯ No

Which ear do you use on the telephone? ◯ Right ◯ Left

Have you had ear infections _____, and/or drainage _____? If so, which ear? _____

Have you ever received medicine or surgery for an ear problem? Describe (include approximate dates):

_____

_____

Have you ever had a skull fracture or concussion? Explain:

_____

_____

Do you have "ringing" or other noises (Tinnitus) in your ears or your head? ◯ Yes ◯ No

If yes, which ear(s)? ◯ Right ◯ Left ◯ Both When is it present? ◯ Constantly ◯ Occasionally ◯ Unsure

When did it begin? _____ How long does it last? _____

Describe what it sounds like to you:

_____

How much does it bother you? (1 = slight, 5 = most severe): ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5

Do you experience dizziness such as spinning, falling, floating, etc.? ◯ Yes ◯ No

If yes, describe (how often, what causes it, any other associated problems): _____

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Have you been around noise that may have affected your hearing? ◯ Yes ◯ No

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If yes, describe:

Military (artillery, jets, tanks, etc.): _____ Years _____

Work (noisy factory, construction, etc.): _____ Years _____

Recreation (hunting, chain saws, etc.): _____ Years _____

Did/do you use hearing protection consistently? ◯ Yes ◯ No

What kind of hearing protection do you use? ◯ Earplugs ◯ Earmuffs ◯ Both

Is there a history of hearing loss in your family? ◯ Yes ◯ No

If yes, who in your family and what caused their hearing loss? _____

_____

Do family members or friends complain about your hearing? _____

Have you had a hearing test before? ◯ Yes ◯ No

Where? _____ When? _____

If known, what were the results? _____

_____

Have you ever worn a hearing aid(s)? ◯ Yes ◯ No

If yes, what make are/were your hearing aids? _____

Where obtained: _____ When obtained: _____ Effectiveness: _____

Comments: _____

Do you take medications regularly? ◯ Yes ◯ No

If yes, what medications do you take? ***Please fill out attached medications form.*** _____

Have you ever been given drugs that you were told might affect your hearing or balance? ◯ Yes ◯ No

If yes, what were you given? _____

Check any that you have or had:

◯ Meningitis	◯ Cancer	◯ Macular Degeneration	◯ HIV AIDS
◯ Diabetes	◯ Malaria	◯ Chemotherapy	◯ Vision Problems
◯ Asthma/Lung	◯ Scarlet Fever	◯ High Blood Pressure	◯ Dexterity Difficulties
◯ Cleft Palate	◯ Mumps	◯ Heart Problems	
◯ Head Injuries	◯ Allergies	◯ Hepatitis A B C D	

Comments:

_____

Patient or Guardian Signature _____ Date _____

Examiner _____ Date _____

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Companion Questionnaire

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Name _____ Patient Name _____

Relation to Patient _____ Date _____

In our professional experience, we have found that many of our patients describe hearing loss as the perception of Sound Voids® that affect not only their normal daily routines but the lives of those around them. We would like to ask you a few situational questions to better understand your companion's listening lifestyle and how we might improve their quality of life.

How often does a hearing problem...	Always	Sometimes	Never
Make it difficult for your companion to converse on the telephone?	◯	◯	◯
Cause you to complain that your companion turns up the television or radio too loud?	◯	◯	◯
Cause your companion to have difficulty following conversations in a restaurant?	◯	◯	◯
Limit or hamper your companion's personal or social life?	◯	◯	◯
Cause your companion to have to ask people to repeat themselves?	◯	◯	◯
Cause your companion to have difficulty hearing when in the presence of background noise?	◯	◯	◯
Cause your companion to have difficulty hearing women's or children's voices?	◯	◯	◯
Cause your companion to hear people speak but fail to understand what they are saying?	◯	◯	◯
Cause your companion to feel as though others mumble?	◯	◯	◯
Cause your companion to feel stressed or tired when listening for long periods of time?	◯	◯	◯

Please provide the top three listening situations where you would like your companion to hear better.

1. _____

2. _____

3. _____

Please select your companion's current and (if different) desired lifestyles.

Active Lifestyle (Frequent Background Noise)

◯ Current ◯ Desired

Casual Lifestyle (Occasional Background Noise)

◯ Current ◯ Desired

Quiet Lifestyle (Limited Background Noise)

◯ Current ◯ Desired

Very Quiet Lifestyle (Rare Background Noise)

◯ Current ◯ Desired

Medication Documentation

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In order for us to provide the best healthcare, it is important for us to know the medications you are taking. Please fill out this form and bring with you to your appointment.

Below, please list each medication you are currently taking including the following: prescriptions, over-the-counter medicine, herbals and vitamin/mineral/dietary supplements.

Medication Name	Dosage	Frequency	Oral, shots, dermal, etc	Condition it is Treating

Patient or Guardian Signature _____ Date _____

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