Better Sound Audiology Adult Case History Form

Diane E Williams, Au.D.
Doctor of Audiology

Patient's Name: _____**Appointment Date:**_____

Date of Birth: _____ **Age:** _____ **Gender:** Male Female

Status Marital: Single Married Divorced Widowed **Spouse Name:** _____

Primary Language: _____ **Social Security Number:** _____

Address _____
Street City State Zip

Home Phone #: _____ **Cell Phone #:** _____

Email: _____

Current Employment: Full-time Part-time Retired Unemployed Stay at Home Parent Student

Current Employer (If retired list prior occupation): _____

Position: _____ **Family Physician:** _____

Have you or your spouse ever been in the military? Yes_____ No_____ Branch:_____# of years:_____

Whom may we thank for referring you: _____

Reason for Appointment: _____

Insurance Information - *Please give you insurance cards to our front office staff so we can make a copy for our records.*

Primary Insurance: _____ **Member ID:** _____

Insured's name: _____ **Relationship to insured:** _____

Secondary Insurance: _____ **Member ID:** _____

Insured's name: _____ **Relationship to insured:** _____

FOR HEARING AID WEARERS, PLEASE ANSWER THE FOLLOWING:

Do you experience any of the following with your current hearing aid(s) (please check all that apply):

◊ Some sounds are too loud
◊ Sounds are too soft
◊ Pain: _____
◊ Sounds are tinny or metallic
◊ Trouble cleaning hearing aid
◊ Naturalness of sound
◊ Trouble understanding in quiet
◊ Wind noise
◊ Trouble using telephone
◊ Feedback or whistling
◊ Trouble changing battery
◊ Repair issues
◊ Trouble understanding in noise
◊ Do not like the appearance of aid
◊ Do not like sound of own voice
◊ Cannot tell direction of sound
◊ Short battery life: (Days)_____
◊ Other: _____

Audiologic History

Do you feel you have a hearing loss? Yes No **Which ear?** Right Left Both

If you answered yes, which best describes it? Gradual Fluctuating Sudden

When did you first notice your hearing loss? _____

What do you think is the cause of your hearing loss? _____

Have you ever had a hearing evaluation? Yes No **When/Where?** _____

Which ear do you use to talk on the phone: Right Left

Have you ever worn or tried a hearing aid? Right Ear Left Ear Both Ears

What type and/or style of hearing aid: _____

Please describe your experience: _____

Please answer the following questions:

Does a hearing problem cause you to feel embarrassed when you meet new people? Yes Sometimes No

Does a hearing problem cause you to feel frustrated when talking to members of your family? Yes Sometimes No

Do you have difficulty when someone speaks in a whisper? Yes Sometimes No

Do you feel handicapped by a hearing problem? Yes Sometimes No

Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors? Yes Sometimes No

Does a hearing problem cause you to attend religious services less often than you would like? Yes Sometimes No

Does a hearing problem cause you to have arguments with family members? Yes Sometimes No

Does a hearing problem cause you difficulty when listening to TV or radio? Yes Sometimes No

Do you feel that any difficulty with your hearing limits or hampers your personal or social life? Yes Sometimes No

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? Yes Sometimes No

Please check all medical conditions that apply:

_____ **Developmental Disorders/Delays** *If checked, please explain:* _____

_____ **Dizziness or Unsteadiness** *If checked, is it accompanied by: Vomiting Nausea Ear Noises*

_____ **Ear Deformity** *If checked, Right ear Left Ear Both ears*

_____ **Ear Drainage** *If checked, Right ear Left Ear Both ears*

_____ **Ear Pain** *If checked, Right ear Left Ear Both ears*

_____ **Family History of Hearing Loss** *If checked, who?* _____

_____ **History of Ear Infections** *If checked, Right ear Left Ear Both ears If so, when?* _____

_____ **History of Ear Wax Buildup** Yes No

_____ **History of Noise Exposure** *If checked, please describe?* _____

_____ **Previous Ear Surgery** *If checked, Right ear Left Ear Both ears If so, when?* _____

_____ **Tinnitus/Ringing/Noises in ears** *If checked, Right ear Left Ear Both ears Frequency?* _____

_____ **Other:** *Please describe:* _____

Medical History

Any other illnesses, surgeries, injuries or hospitalizations since birth and their date(s) of occurrence: _____

_____

_____

Allergies (food, medications, plastics, etc.): _____

Have you experienced any of the following major medical conditions:

_____ AIDS/HIV	_____ Diphtheria	_____ High Blood Pressure	_____ Mumps
_____ Appetite Change	_____ Encephalitis	_____ High Fevers	_____ Scarlet Fever
_____ Arthritis	_____ Fatigue	_____ Influenza	_____ Stroke
_____ Blood Disorders	_____ Genetic Disorders	_____ Malaise	_____ Tonsillitis
_____ Cancer	_____ Headaches	_____ Malaria	_____ Typhoid
_____ Chicken Pox	_____ Head Injury	_____ Measles	_____ Vascular Problems
_____ Diabetes	_____ Heart Problems	_____ Meningitis	_____ Other: _____

List All Current Medications (over the counter, prescriptions, or recreational): _____

_____

_____

Do you currently use tobacco? Yes No

Please Check all medical symptoms that apply:

_____Eye Problems (such as blurred vision, pain):

_____Nose, Throat, or Mouth Problems (such as trouble swallowing, nose bleeds, dental issues, pain):

_____Cardiovascular Symptoms (such as hypertension, chest pain, swelling, palpitations):

_____Respiratory Symptoms (such as shortness of breath, cough, wheezing):

_____Gastrointestinal Issues (such as nausea, vomiting, weight changes, diarrhea, pain):

_____Musculoskeletal Symptoms (such as joint pain, swelling, recent trauma):

_____Neurologic Symptoms (such as numbness, headaches, seizures, muscle weakness):

_____Psychiatric Issues (such as depression, anxiety, compulsions):

_____Endocrine Symptoms (such as frequent urination, hot flashes):

_____Hemotologic/Lymphatic Symptoms (such as bleeding gums, bruising, swollen glands):

_____Allergic/Immunologic Symptoms (such as hives, asthma, itching, immune deficiency):

Additional Comments: _____

_____

_____

POLICY

We ask that all office visits and services be paid at the time they are provided. Although we will gladly bill your insurance when possible, you will be responsible for any unpaid balance by your insurance where applicable.

_____
Initials

INSURANCE AUTHORIZATION

I request that payment of authorized benefits be made on my behalf to Better Sound Audiology for services furnished to me by the provider. I authorize any holder of medical information about me to release to Better Sound Audiology any information needed to determine these benefits or the benefits payable for related services.

_____
Initials

AUTHORIZATION TO RELEASE MEDICAL RECORDS

I hereby authorize you to release to my attorney(s), and/or my insurance carrier(s), and/or the referring and/or family doctor, and/or school personnel such medical information as they may require or request.

_____
Initials

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have been given the opportunity to read the NOTICE OF PRIVACY PRACTICES for the office of Better Sound Audiology & Hearing Aid service a copy of which is available in the waiting area. I understand that a copy of this notice will be made available to me at my request.

_____
Initials

_____	_____	_____
Signature of Patient	**Signature of Parent or Guardian if patient is a minor and Relationship to the minor**	**Date**