PERSONAL HISTORY - ADULT

Full Name (circle one): Mr. Ms. Mrs. Dr.
____

Preferred Name: ____ ❑ Male ❑Female

Home Address: ____

City: ____ State: _________________ Zip: ________________

Home Phone: (____) ____________________________ Cell Phone: (____) ____________________________

E-mail Address: ____

What is the best way to reach you? ❑ Home Phone ❑ Cell Phone ❑ E-mail ❑ Other:
____

Date of Birth: ____ Age: ________________________________

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ ______________________

Accompanied by: __________________________________ Relationship: ________________________________

Employer: ____ Your Occupation: ___________________________

Employer's Address: ____

City: ____ State: _________________ Zip: ________________

Business Phone: (____) ______________________________ Is it OK to call at work?: ❑ Yes ❑ No

Family Physician: ____________________________ Physician Phone Number: (____) ____________________

How did you hear about our practice? ❑ Physician ❑ Yellowbook ❑ Radio ❑ Website ❑ Google ❑ Verizon ❑ Yellow Pages ❑ Other: ____

Treatment, Consent, and Billing Agreement

Health Insurance Portability & Accountability Act (HIPPA) Acknowledgement

Authorization for Treatment and Procedures: I hereby agree to and give consent to be treated by *Audiology & Hearing Services of Charlotte, PLLC.*

HIPPA Acknowledgement: By signing below, I acknowledge that I have had access to *Audiology & Hearing Services of Charlotte, PLLC's* notice of Privacy Practices.

Financial Policy: I am financially responsible to *Audiology & Hearing Services of Charlotte, PLLC* for all charges.

Participation in Insurance Products: I relieve *Audiology & Hearing Services of Charlotte, PLLC* of any responsibility in reference to nonparticipation in the insurance or if my services were to be performed by another entity.

Release of Information: I give permission to *Audiology & Hearing Services of Charlotte, PLLC* to disclose all or any part of my medical records to any of my other treating health care providers as needed for treatment purposes. Audiology & Hearing Services of Charlotte, PLLC... will release information as permitted by law and/or HIPPA regulations.

Financial Responsibility: In consideration of the services provided by *Audiology & Hearing Services of Charlotte, PLLC*, I completely understand and fully agree that I have full responsibility to pay *Audiology & Hearing Services of Charlotte, PLLC* for all services rendered. I hereby guarantee full payment of all charges

____ ____
Signature of Responsible Party *Date*

HEALTH HISTORY

Do you hear people speaking but have difficulty clearly understanding what is being said?

When did you first notice the problem? ____________________________ Was it ❑ gradual or ❑ sudden?

What do you feel caused your problem? ____

Have you seen a physician for your hearing? If so, whom and when? ______________________________

List some sounds you find excessively loud: ____

Do you find normal conversation to be excessively loud? ____

Where is the sound sensitivity primarily located?

❑ Right ear ❑ Left ear ❑ Both ears equally

Your sound sensitivity is (check one):

❑ Fairly constant from day to day

❑ Fluctuates widely, being very loud some days and very mild other days

❑ Usually constant, but occasionally decreases markedly

❑ Usually constant, but occasionally increases markedly

Please indicate all the situations where you have been exposed to loud noises:

❑ Work ❑ Home ❑ Hobbies ❑ Shooting guns ❑ Loud music

Please check any of the following situations where you notice sound sensitivity appears worse:

❑ When tired

❑ When tense or nervous

❑ At bedtime

❑ After use of alcohol

- ❑ Upon awakening
- ❑ When relaxed

Is there a time of day when your sound sensitivity is most troublesome to you?

- ❑ At work
- ❑ In morning
- ❑ In evening
- ❑ When trying to concentrate
- ❑ At social activities
- ❑ Around noise
- ❑ Others: ____

Do you wear hearing protection in the presence of loud sounds?

- ❑ Yes
- ❑ No

If yes, how often do you wear hearing protection? ____

Do you consider yourself to be a tense person? ____

Do you feel that emotional or physical stress worsens the sound sensitivity?_____________________________

How does your sound sensitivity interfere with your activities?

Concentration: ____

Work/chores: ____

Family: ____

Religious Activities: ____

Social/recreation: ____

Exercise: ____

Sleep: ____

Other: ____

Treatment History:

Please list all evaluations and/or treatments (including psychiatric, psychological, MRI, CT scan, etc.) you have had for your sound sensitivity. Please include the names of specialists who have performed evaluations or treatments, and the appropriate dates on which they were performed, using the reverse side if necessary.

	Provider	**What was done?**	**Date**	**Result**
1				
2				
3				
4				
5				

Please list all medications and supplements you currently take:

Medication	**Dose**	**How often?**	**Purpose?**	**Doctor**

MEDICAL HISTORY

Please check all that are applicable to you:

____Poor health for most of your life

____History of middle ear disease

____History of Meniere's disease

____History of otosclerosis

____History of facial pain/numbness/paralysis

____History of labrynthitis

____History of mastoiditis

____History of ear surgery

____Migraine headaches

____Hyperventilation syndrome

____Hypertension (high blood pressure)

____Cancer

____Dizziness/imbalance, or vertigo

____Arthritis

____Heart disease

____ OCD

____Depression

____Increased use of drugs or alcohol

____Fair to poor dietary habits

____Moderate to excessive use of caffeine (cola, coffee, chocolate)

____Low back pain

____Whiplash or neck injury

____Hyperacusis is altered by change in position

____Stiffness or reduced mobility of neck

____Headaches that change with head movement

____Tenderness/pain in jaw with or without chewing

____Clenching or grinding teeth

____Personal or family history of diabetes/ thyroid problems/autoimmune disease/high cholesterol

____Personal or family history of inhalant or food allergies

____History of Epstein-Barr virus, cytomegalovirus, or hepatitis

____Lyme disease

____

List any operations ____

Other chronic illnesses ____

Any drug or other allergies ____