Audiology & Hearing
SERVICES OF CHARLOTTE

Today's Date:_____

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

_____

Date of Birth: _____

PERSONAL HISTORY - ADULT

Age: _____

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: _____

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: _____

Please list persons (family members, doctors, etc.) with whom you give us permission to discuss your health information, send reports, and schedule future appointments:

- Referring Physician - _____
- Primary Care Physician - _____
- Other Physician - _____
- Family Member (s) - _____
- Other - _____

List power of attorney's contact information (if applicable) _____

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MEDICAL HISTORY

Please check all medical symptoms that apply:

	Left Ear	Right Ear	Both	Dates of occurrence:
Ear Pain				
Ear Infections				
Ear popping				
Ear Surgery				
Ear Tubes				
Ear Drainage				
Ears Ringing				
Trauma (Head/ Ear)				
Ear Deformity				
Dizziness or unsteadiness				

Have you had any of the following? Please check all of those that apply.

❑ Alzheimer's/ Dementia ❑ Arthritis ❑ Cancer

❑ Depression/Anxiety ❑ Diabetes ❑ Heart problems

❑ High Blood Pressure ❑ Measles ❑ Meningitis

❑ Multiple Sclerosis ❑ Mumps ❑ Stroke/TIA

❑ Decreased Feeling in Fingers ❑ Other_____ ❑ Other_____

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Please check all medical symptoms and conditions that apply:	YES	NO
Eye problems (such as blurred or double vision or pain)		
Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)		
Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)		
Respiratory issues (such as shortness of breath, cough, wheezing		
Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain):		
Musculoskeletal issues (such as joint pain, swelling, recent trauma)		
Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness):		
Psychiatric issues (such as depression, anxiety, compulsions)		
Endocrine symptoms (such as frequent urination, hot flashes)		
Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)		
Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)		

List any operations _____

Other chronic illnesses _____

Any drug or other allergies (including latex/plastics)_____

Do you currently use any recreational drugs? ❑ Yes ❑ No

If yes, what drugs? _____

How often? ❑ Daily ❑ Weekly ❑ Monthly ❑ Occasionally ❑ Rarely

Do you currently drink alcohol beverages? ❑ Yes ❑ No

If yes, how often? ❑ Daily ❑ Weekly ❑ Monthly ❑ Occasionally ❑ Rarely

Have you smoked a cigarette, cigar, e-cig (vape), tobacco, one or more times in the past 24 months? ❑ Yes ❑ No

If yes, how often in the past 24 months? _____Amount of use per day? _____

If yes, what do you use? ❑ Cigarette ❑ Cigar ❑ Pipe ❑ E-cig (vape) ❑ Other_____

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Please list all current medications or attach a list:

NAME	DOSE (MG)	FREQUENCY (Example:1 a day)	DELIVERY METHOD (Example: Oral , Shot, Eye drops)

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Today's Date:_____

Full Name: _____

HEARING LOSS HISTORY - ADULT

What is your primary reason for coming in today?_____

If you suspect a hearing loss, how long have you noticed this problem?_____

Was it ❑ gradual or ❑ sudden?

In which ear do you hear best? ❑ Right ❑ Left ❑ Same in both

What do you feel caused your hearing problem? _____

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

Do any family members have hearing problems? ❑ Yes ❑ No

If so, whom, and at what age was it identified?

_____

Is hearing loss causing any issues at work? ❑ Yes ❑ No Please explain_____

_____

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

❑Work	❑Home	❑Hobbies
❑Shooting Guns	❑Loud Music	❑ Other_____

Please check any of the following situations where you notice hearing difficulty:

❑Television	❑Radio	❑Movies
❑Place of Worship	❑Small groups	❑Meetings
❑ In noisy restaurants	❑ Other_____	❑ Other_____

List 3 Areas where you have the most difficulty hearing or understanding:

1. _____
2. _____
3. _____

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HEARING AID HISTORY

Do you currently wear hearing aids? ❑ Yes ❑ No

If yes, which ear uses a hearing aid? ❑ Right Only ❑ Left Only ❑ Both

Do you wear your hearing aid(s) regularly? □ Yes □ No

Do you feel you would benefit from hearing aids? □ Yes □ No

List any Problems you are having with your hearing aids:_____

What would you improve about your current hearing aid technology?_____

_____

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Acknowledgement

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.*

_____ **(initial here) HIPPA Acknowledgement:** By initialing this section and signing below, I acknowledge that I have had access to *Audiology & Hearing Services of Charlotte, PLLC*'s notice of Privacy Practices. The Notice provides information about how we may use and disclose the medical information that we maintain about you. We encourage you to read the full Notice. I understand that a copy of the current Notice will be available in the reception area, the website (if applicable) and that any revised Notice of Privacy Practices will be made available upon request.

_____ **(initial here) Participation in Insurance Products:** By initialing this section and signing below, 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.

_____ **(initial here)Release of Information:** By initialing this section and signing below, 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.

_____ **(initial here) Educational and/or Marketing Information:** By initialing this section and signing below, I authorize *Audiology & Hearing Services of Charlotte, PLLC* to send me educational and/or marketing information on the products and services offered by *Audiology & Hearing Services of Charlotte, PLLC*. No remuneration is involved in this communication. I understand that I may revoke this authorization, in writing, at any time.

_____ **(initial here) Financial Responsibility** By initialing this section and signing below, I agree to accept the financial policies of *Audiology & Hearing Services of Charlotte, PLLC*. I understand that payment in full is due on the date of service, including all co-pays, co-insurance, deductibles, and payment for non-covered services.

Printed Name:_____

Signature of Patient or Guardian: _____

Date: _____

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Characteristics of Amplification Tool (COAT)

Name: _____ Date: _____

Our goal is to maximize your ability to hear so that you can more easily communicate with others. In order to reach this goal, it is important that we understand your communication needs, your personal preferences, and your expectations. With this information, we can use our expertise to make a recommendation of hearing aids or other solutions that are most appropriate for your individual needs.

1. Please list the top three situations where you would most like to hear better. Be as specific as possible.

_____

_____

_____

2. How important is it for you to hear better?

Not very important 1 2 3 4 5 *Very important*

3. How motivated are you to wear and use hearing technology?

Not very motivated 1 2 3 4 5 *Very motivated*

4. How well do you think hearing technology will improve your hearing?

Not be helpful at all 1 2 3 4 5 *Greatly improve my hearing*

5. How confident do you feel that you will be successful in using hearing technology?

Not very confident 1 2 3 4 5 *Very confident*

6. What is your most important consideration regarding hearing technology? Rank order the following factors with 1 as the most important and 4 as the least important. Place an X on the line if the item has no importance to you at all.

___ Hearing aid size and the ability of others not to see the hearing aids

___ Improved ability to hear and understand speech

___ Improved ability to understand speech in noisy situations (e.g., restaurants, parties)

___ Cost of the hearing aids

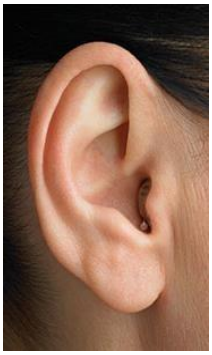
7. Do you prefer hearing aids that: (check one)

___ are totally automatic so that you do not have to make any adjustments to them

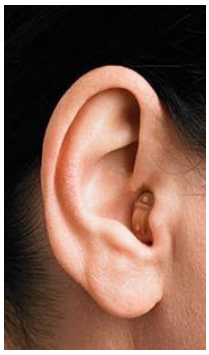
___ allow you to adjust the volume and change the listening programs as you see fit

___ no preference

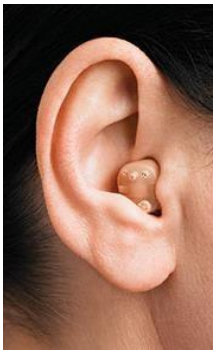
8. Please place an X on the pictures of the hearing aid(s) that you WOULD be willing to wear.



☐ Micro CIC



☐ CIC



☐ Half Shell

☐ Full Shell

☐ BTE

☐ RIC