Appalachian Hearing & Balance
1242 Hockman Pike
Bluefield, VA 24605
www.MountainEars.com
(276)326-3890

Instructions for VNG testing

1. **If your appointment is before 12:00 pm do not eat breakfast. If your appointment is after 12:00pm do not eat lunch. (If you are a diabetic go ahead and eat at your scheduled time)**

2. **DO NOT take any unnecessary medication for 24 hours, this Includes Antivert, Meclizine, sleeping pills, pain medication and Depressants. (Heart and blood pressure medications are fine).**

3. **Abstain from alcohol for 48 hours before testing. No coffee, caffeine or sodas the day of the test.**

4. **No make-up (including mascara and eye liner). You will be asked to remove glasses and/or contact lenses before testing.**

5. **Do not smoke two hours before the test.**

6. **Wear loose, comfortable clothing and flat heeled shoes for the test.**

7. **You will have a follow up appointment to go over the results.**

IF YOU NEED TO CANCELL YOUR APPOINTMENT PLEASE DO SO 24 HOURS PRIOR TO YOUR APPOINTMENT TIME OR YOU WILL BE CHARGED A <u>$100.00 OFFICE FEE.</u>

Appalachian Hearing & Balance
Doctors of Audiology
1242 Hockman Pike
Bluefield, VA 24605
(276)326-3890

Dizziness Questionnaire

Name:______________________________ Date:__________________

Please answer ALL of the following questions by circling yes or no

1.	Light headedness	Yes	No	
2.	Swimming sensations in your head	Yes	No	
3.	Blacking out	Yes	No	
4.	Loss of consciousness	Yes	No	
5.	Tendency to fall	Right	Left	Forward/Backward
6.	Objects spinning or turning around you	Yes	No	
7.	Sensation that YOU are turning or spinning inside, with outside objects remaining stationary	Yes	No	
8.	Loss of balance when walking veering to the	Right	Left	
9.	Headache	Yes	No	
10.	Nausea	Yes	No	
11.	Vomiting	Yes	No	
12.	Pressure in your head	Yes	No	

Please circle the answer that best applies to you

1.	Do you have pain in	Both Ears	Right Ear	Left Ear	No
2.	Do you have discharge from	Both Ears	Right Ear	Left Ear	No
3.	Do you have double vision	Constant	In episodes		No
4.	Blurred vision	Constant	In episodes		No
5.	Numbness in your face	Constant	In episodes		No
6.	Numbness in your arms and legs	Constant	In episodes		No
7.	Weakness of your arms and legs	Constant	In episodes		No
8.	Mental Confusion	Constant	In episodes		No
9.	Loss of consciousness	Constant	In episodes		No
10.	Difficulty with speech	Constant	In episodes		No
11.	Difficulty with swallowing	Constant	In episodes		No

Over

Please fill in the following blanks:

1. When did the dizziness first occur?______________________________

2. Are you dizzy all the time: Yes No

3. Does your dizziness occur in attacks?______________ If so how often?______________
   How long do the episodes last?______________________________
   Can you tell when an attack is about to start?____________If so how?______________

4. Are you completely free of dizziness between attacks? Yes No

5. Does change of position make you dizzy? Yes No

6. Do you have trouble walking in the dark? Yes No

7. When you are dizzy can you stand up unsupported? Yes No

8. Do you know a possible cause for your dizziness?____________ If so what?____________
   ____

9. Do you know of anything that will:
   Stop your dizziness or make it better? What?______________________________
   Make your dizziness worse? What?______________________________
   Bring on an attack?______________________________

10. Is there any relationship between eating and your dizziness? If so what?______________

11. Were you exposed to irritating fumes, paint, ect.... at the onset of your dizziness?________

12. Do you have allergies? What?______________________________

13. Have you ever seriously injured your head?____________When?______________
    Were you unconscious?______________ How long?______________

14. List all medications you take regulary:______________________________

15. Do you think you are under any unusual strain or tension?______________________

16. Has anyone in your family had similar dizziness?_____________Who______________

17. Have you been hospitalized in the last three years?________ for what?______________

18. Do you now, or have your ever had kidney failure and need dialysis?______________

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Welcome to Appalachian Hearing & Balance, we want to provide excellent hearing care to you. Please tell us a little about yourself by completing this form.

PERSONAL INFORMATION:

PATIENT'S NAME ____
FIRST MIDDLE LAST

MAILING ADDRESS ____

CELL PHONE ____________________ EMAIL ____________________

TELEPHONE (HOME) ____________ (WORK) ____________ SS# ____________

BIRTHDATE ____________ AGE ______ MALE ____ FEMALE ____ MARITAL STATUS ________

EMPLOYER ____________________ OCCUPATION ____________________

FULL NAME AND PHONE NUMBER OF PRIMARY CARE PHYSICIAN ____________________

WHOM MAY WE CONTACT IN CASE OF EMERGENCY ____________________

WHO REFEFFED YOU TO OUR OFFICE ?

We like to know how our patients find our practice. If your physician, a family member, advertisement, or a friend sent you in, we want to thank them. If you learned about our office another way, it is helpful that we know.

HOW DID YOU HEAR ABOUT US? ____

INSURANCE INFORMATION - PLEASE READ AND SIGN/INITIAL:

DISCLAIMER:** As a professional courtesy, we will submit your claim to your insurance provider, but this does not guarantee their payment. You accept responsibility for co-pay, deductibles, or uncovered procedures.* ***PLEASE INITIAL: ________

PLEASE BRING YOUR INSURANCE CARD(S) WITH YOU TO BE COPIED FOR YOUR FILE.
If health insurance is not in your name, please provide the following information:

____________________ ____________________
Name of insured Relationship to patient

____________________ ____________________
Insured's Date of Birth Insured's Employer

I hereby authorize Appalachian Hearing & Balance to furnish information to my insurance carrier concerning my illness and treatment, and I hereby assign to her all payments for services rendered to my dependents or myself. I understand that I am responsible for payment.

SIGNATURE ______________________________ DATE ____________

PLEASE READ AND SIGN/INITIAL:

In order to keep your medical file up to date, we will be happy to provide your physician with a copy of our audiological findings. ***Please initial ONE*** ➔

Send a copy to my physician ______ (initial)

DO NOT send a copy to my physician ______ (initial)

MEDICAL:

Do you have pain/discomfort in your ear? Right _____ Left _____ Both _____

Do you have you any drainage in your ear? Right _____ Left _____ Both _____

Do you have a history of ear infections? Right _____ Left _____ Both _____

Do have ringing or other noises in your ear? Right _____ Left _____ Both _____ Is it constant or intermittent?

Do you have dizziness or vertigo? Yes _____ No _____

Have you ever had ear surgery? Right _____ Left _____ Both _____

Please describe ______________________________

Have you seen your physician regarding any of the above? ______________________________

Please describe other medical conditions we should be aware of: ______________________________

PLEASE BRING A LIST OF YOUR MEDICATIONS TO YOUR APPOINTMENT.

Do you take any prescription medications on a regular basis? Please list:

Medication: ______________________ For: ______________________

Medication: ______________________ For: ______________________

Please check any of the following that you currently have or have had in the past:

Meningitis___ Mumps___ Asthma___ Scarlet Fever___ High Blood Pressure___ Diabetes___

Heart Trouble___ Lung Trouble___ Transplant___ Malaria___ Neurological Symptoms___

Head Injury___ Stroke/TIA___ Parkinson's___ Bell's Palsy___ Measles___ Arthritis___

Cancer/Type______________ (please mark if any treatment)-Radiation Y/N, Chemotherapy Y/N

HEARING:

Do you think you have a hearing loss? Yes_____ No_____

Is there a family history of hearing loss? Yes_____ No_____ If yes, who: ______________________

Have you had noise exposure? Yes_____ No_____

If yes, from work/military/hobbies, etc., please specify ______________________

Have you had your hearing tested before? Yes_____ No_____ When__________ Results__________

Do you currently use a hearing aid? Yes_____ No_____

If yes, How long? ______ What type? ______________ Are you satisfied with it? Yes____ No____

Mark the areas you have difficulty hearing/understanding and rate the level of the problem as follows:

Never ❶ ¼ of the time ❷ ½ of the time ❸ ¾ of the time ❹ Always ❺

Communication difficulties when speaking with one person (i.e., spouse, store clerk) _____

Communication difficulties when speaking with small group (i.e., small dinner party, playing cards) _____

Communication difficulties when in a large group (i.e., church, club, meetings, lectures) _____

Communication difficulties with various types of entertainment (ex., movies, TV, theatre) _____

Communication difficulties when in a noisy environment (i.e., riding in a car, restaurants, parties) _____

Communication difficulties using communication devices (i.e., telephone, doorbell, PA systems) _____

Do you feel your hearing limits your personal or social life? Yes____ No____ If yes, please rate _____

Do problems or difficulty with your hearing upset you? Yes______ No_____

Do other people suggest you have a hearing problem? Yes_____ No_____

Do people leave you out of conversations or become annoyed because of your hearing? Yes____ No___

MEDICATION RECORD

Name: ______________________________ Date: ____________________

Please list ALL medications including ASPIRIN and any VITAMIN SUPPLEMENTS

Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am / pm

If you need more space please feel free to use the back of this form

Please rank the following in order of importance (1-4), If a hearing aid is recommended for you:

_____Improved hearing in quiet   _____ Improved hearing in noise
_____Cosmetic appearance   _____ Expense

We believe in, and strive to provide, a convenient location with ample parking and expect our staff to always be professional, courteous and helpful. To provide you with the highest level of service, please rate your experience of the following areas:

Location and accessibility	___ Excellent	___ Average	___ Poor
Adequate of Parking	___ Excellent	___ Average	___ Poor
Convenience of appointment times	___ Excellent	___ Average	___ Poor
Friendly greeting	___ Excellent	___ Average	___ Poor
Clean and welcoming environment	___ Excellent	___ Average	___ Poor

What can we do to make your next visit more comfortable?___________________________________

____

By signing below, you agree to give consent to, and agree to hold harmless (agree not to file suit or claim for damages), the audiologist, to perform cerumen removal and/or earmold impressions, if so needed. These procedures add an element of risk to the eardrum and ear canal. Some of the risk included, but are not limited to, eardrum perforations (rupture), laceration (cut), and bruising of the ear canal wall. Placing a hearing aid in the ear canal, also runs the risk listed above.

Please tell us anything else you want to share about your hearing ______________________________

NOTES:

_______________________________   _______________________________
Signature   Today's Date

Patient Health Questionnaire (PHQ-9)

Name: ______________________ Date: ______________

Over the *past 2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: ______ + ______ + ______

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) **Total:** ______

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ______
Somewhat difficult ______
Very difficult ______
Extremely difficult ______

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NYC Health
nyc.gov/health
THE NEW YORK CITY DEPARTMENT of HEALTH and MENTAL HYGIENE
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Thomas R. Frieden, M.D., M.P.H., Commissioner
Lloyd I. Sederer, M.D., Executive Deputy Commissioner for Mental Hygiene

TAKE CARE NEW YORK
GET HELP FOR DEPRESSION: A Key Step to a Healthier New York

Medical Release of Records

The undersigned herewith authorized Appalachian Hearing & Balance to receive and/or release medical data, medical history and/or other information to any hospital, physician, agency or person for such a release of information for the purpose of consultation, prescription or future treatment and in the interest of the proper management of my disability.

□ By signing below you authorize Appalachian Hearing & Balance to occasionally send you text messages and emails about promotions or information about our practice.

____

Patient, Parent or Guardian Signature/Date

____

Witness/Date

Effective Date: January 1, 2003

* **Provider Note: You should consult your state law to avoid potential conflicts or contradictions with the uses and disclosures defined in this document.**

* **I have read the undersigned and understand the Notice of Privacy Practices.**

______________________________ ______________________________
Patient Signature Date
or

______________________________ ______________________________
Patient Representative Date

____
Relationship to Patient

Can confidential messages (i.e. appointment reminders) be left on your answering machine, voice mail or with a family member?

_______Yes _____No

Please list persons that you authorize release of information to regarding your visits/account including all physicians, schools or agencies you have seen or have referred you

______________________ Physician______________________ Phone ________________

______________________ Relationship____________________ Phone________________

______________________ Relationship____________________ Phone________________

______________________ Relationship____________________ Phone________________

______________________ Relationship____________________ Phone________________