Appalachian Hearing & Balance
1242 Hockman Pike
Bluefield, VA 24605

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_____
ADDRESS CITY STATE ZIP

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

_____ _____
Insuredôs Date of Birth Insuredôs 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 check the box if you wish to have records sent to your physician Ĩ

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 _____
Do you have a fear of falling? 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.
Use the provided page to list ALL of your medications. Please include Aspirin and Vitamin Supplements.

Please check any of the following that apply to you or have applied to you in the past:
Meningitis_____ Mumps____ Asthma____ Scarlet Fever____ High Blood Pressure____ Diabetes____
Heart Trouble____ Lung Trouble_____ Transplant_____ Malaria_____ Neurological Symptoms_____
Head Injury_____ Stroke/TIA_____ Parkinsonôs____ Bellôs Palsy_____ Measles_____ Arthritis_____
Cancer/Type_____ (please mark if any treatment)-Radiation Y/N, Chemotherapy Y/N

Depression _____ Anxiety _____, if yes, are you currently being treated? Yes____ No____

Are you **currently** a tobacco user? Yes _____ No _____

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___

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

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

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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_____

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1242 Hockman Pike
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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 $100.00 OFFICE FEE.

Dizziness Questionnaire

Name:_____ Date:_____

Please answer <u>ALL</u> 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

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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? _____

11. Were you exposed to irritating fumes, paint, etc. 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 regularly: _____

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 you ever had kidney failure and need dialysis? _____