Treasure Coast Audiology, Inc.
2340 NE Dixie Hwy
Jensen Beach, FL 34957
7550 US1
Vero Beach, FL 32967

WELCOME !

What to Expect at your Appointment?

If you have come to us for help with a balance issue, your visit will include a variety of simple but technically advanced tests using computers and highly specialized equipment. Your testing will include a complete hearing exam as well as a collection of tests designed to help determine the cause of your balance or dizziness problems. The audiologist or technician will provide an explanation prior to each test or procedure so that you will have a better understanding of what is being tested and why. The audiologist will discuss the results whenever possible and send all results to your referring physician. Your appointment will last about 90 minutes.

In order to assist you effectively, we ask that you please review the following instructions carefully:

- ○ Bring your photo ID, insurance card(s) and completed patient information packet.
- ○ Bring any existing hearing tests and information related to your hearing, including dates and scope of medical procedures performed on the ear (inside or out), dates of injuries to the head and ears, etc.
- ○ Bring the any hearing assistive devices, that you may be currently using, if any.
- ○ Please do not wear any makeup, including mascara, eye liner, or face lotions. These products might interfere with the instrument recordings.
- ○ Please do not drink alcoholic beverages for 48 hours before the testing day.
- ○ Certain medications can influence the body's response to the test, thus giving a false or misleading result.

  If possible, please refrain from taking any of the following medications for 48 hours prior to your appointment:
  Anti-vertigo medicines like Anti-vert, Ru-vert or Meclizine (Dramamine);
  Anti-nausea medicines like Atarax, Compazine, Antiver, Bucladin, Phenergan, Thorazine, Scopalomine, or Transdermal.
- ○ Vital medications SHOULD NOT be stopped. Continue to take medications for heart, blood pressure, thyroid, anticoagulants, birth control, antidepressants, and diabetes. If you are unsure about discontinuing a particular medication, please call your physician to determine if it is medically safe for you to be without them for 48 hours.
- ○ Eat lightly the day of your appointment. If your appointment is in the morning, you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch.
- ○ Testing may cause a sensation of motion that may linger. If possible, we encourage you to have someone accompany you to and from your appointment. However, if this is not possible, try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.
- ○ Bringing a family member who is familiar with your hearing and/or balance health , who can share their perspective of your health is very helpful. For non-English speaking patients, it may also be helpful to bring a family member or friend to translate, as the tests that will be performed may be interactive and require a response. Hearing and speaking are two sides of the communication equation, so we want to make sure we can understand each other!
- ○ Bring a valid means of payment. Payment is due at the time of service.

Thank you for choosing **Treasure Coast Audiology** for your hearing needs!

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Patient Information

First Name:_____ Middle:_____ Last:_____ ☐ Male ☐ Female

Address:_____ Apt/ Unit:_____

City:_____ State:_____ Zip:_____

Home Phone #:_____ Work:_____ Cell #:_____ E-Mail:_____

Social Security #:_____-_____-_____ Date of Birth:_____/_____/_____ Age:_____ Martial Status: _____

Spouse First Name:_____ Middle:_____ Last:_____

Home Phone #:_____ Work:_____ Cell #:_____ E-Mail:_____

Emergency Contact:_____ Phone #:_____ Relationship:_____

Do you live in a skilled Nursing or Assisted Living Facility, or Rehab Center? ☐ Yes ☐ No

Facility Name:_____ Phone #:_____

Are you a seasonal resident of Florida? ☐ Yes ☐ No What is your northern/ other address?

Address:_____ Apt/ Unit:_____

City:_____ State:_____ Zip:_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Occupation:_____ How long? _____

Employer_____ Address:_____

Medical Doctor Information:

Referring Physician:_____ Phone #:_____

Address:_____ City:_____ State:_____ Zip:_____

Family Physician:_____ Phone #:_____

Acknowledgement of Payment (Check All That Apply)

☐ Cash ☐ Check ☐ VISA ☐ Mastercard ☐ Discover

Primary Insurance:_____ ID#:_____ Group #:_____

Primary Card Holder Name: _____ Primary Card Holder Date of Birth:_____/_____/_____

Secondary Insurance Name:_____ ID#:_____ Group #:_____

INITIAL HERE ☐ I understand that I am ultimately responsible for the balance on my account for any professional services rendered. I authorize your office to release any information relating to the services obtained here and those services related to my treatment here to other professionals and insurers as may become necessary. I authorize the release of any medical information necessary to process this

Authorization for Treatment

The patient / legal guardian authorized **Treasure Coast Audiology, Inc.** to administer appropriate testing and / or treatment for the patient's diagnosis / rehabilitation. The patient / legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature:_____ Date:_____

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Medical History

Patient Name:_____ Date of Birth: ____/____/____ Today's Date ____/____/____

Prescriptions	Dosage	Frequency

Over the Counter/ Supplements & Vitamins	Dosage	Frequency

Surgeries	Date

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Patient Neurodiagnostic Intake

Patient Name:_____ Date of Birth: ____/____/____ Today's Date ____/____/____

Neurologic

- ☐ Migraine
- ☐ Stroke/ TIA
  If so, when? _____
- ☐ Parkinson's Disease
- ☐ Seizures/ Epilepsy
- ☐ Concussion/ Head Injury
  If so, when? _____
- ☐ Multiple Sclerosis
- ☐ Alzheimer's
- ☐ Other Neurologic

Cardiovascular

- ☐ Heart Attack
  If so, when? _____
- ☐ Pacemaker
- ☐ Peripheral Arterial Disease
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Other Cardiovascular _____

Respiratory

- ☐ Breathing Difficulties
- ☐ Emphysema/ COPD
- ☐ Asthma
- ☐ Other Respiratory _____

Other Health Issues

_____

_____

_____

_____

_____

_____

Orthopedic

- ☐ Artificial Joints
  If Yes, which? _____
- ☐ Arthritis
- ☐ Back Problems
- ☐ Back Surgery
  If so, when? _____
- ☐ Neck Problems
- ☐ Osteoporosis/ Osteopenia
- ☐ Other Orthopedic _____

Vision

- ☐ Cataracts
  If removed, when? _____
- ☐ Glaucoma
- ☐ Macular Degeneration
- ☐ Other Vision _____

Other

- ☐ Cancer
  Type: _____
- ☐ Diabetes
- ☐ Neuropathy
- ☐ Depression
- ☐ Anxiety
- ☐ Thyroid
- ☐ Gastrointestinal Problems
- ☐ Rheumatoid Arthritis
- ☐ Tobacco Use
  If Yes, how much? _____
- ☐ Alcohol Use
  If Yes, how much? _____

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Patient Neurodiagnostic Intake

PATIENT NAME: _____ DATE: _____

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability, but please be assured that how you answer will not affect your evaluation.

Please state briefly the nature of your problem: _____

How or when did your problem first occur? _____

How long did it last? _____

Have your symptoms **improved** / **changed** / **stayed the same** since they began? If improved or changed, how so?

If improved or changed, how so? _____

Does anything make your symptoms worse? _____

Does anything make your symptoms better? _____

Which of the following best describes your symptoms?

- O Imbalance
- O Falling more often
- O World spinning around you
- O You feel as if you are spinning; the World is not spinning
- O Nausea
- O Lightheadedness
- O Other: _____

How long do your symptoms last *without* stopping?

- O Seconds
- O Minutes
- O Hours
- O Days
- O Symptoms are constant

How many times per day / week / month / year (*circle one*) do you have an episode? _____

Did any of the following occur prior to your symptom onset? (*check all that apply*)

- O Head trauma
- O Motor Vehicle Accident
- O Change in medication
- O A fall
- O A virus or infection, e.g. Shingles, Cold, Sores, COVID-19
- O Surgery
- O Stressful event or high stress
- O Other: _____

Do you have a history of migraines? YES / NO If YES, when was your most recent migraine? _____

Do any of the following trigger your symptoms? (*check all that apply*)

- O Increased stress
- O Skipping a meal
- O Not drinking enough water
- O Changes in weather
- O Certain foods: _____

PATIENT NAME: _____ DATE: _____

Do any of the following accompany or occur immediately prior to an episode of your symptoms?

(*check all the apply*)

- O Headaches
- O Neck pain
- O Hearing loss: right ear / left ear / both ears (*circle one*)
- O Fullness in your ear(s): right ear / left ear / both ears (*circle one*)
- O Ringing in your ear(s): right ear / left ear / both ears (*circle one*)
- O Shimmers or Sparkles in your vision
- O Sensitivity to light / sound / smell (circle all that apply)

Please review the following questions, answering YES or NO as appropriate and filling in the blanks with additionally requested information.

Y	N	Do you experience motion, air or sea sickness?
Y	N	Did you have motion sickness as a child?
Y	N	Do you have a family history of motion sickness? O Parent O Sibling O Child
Y	N	Were you exposed to any solvents, chemicals, etc.?
Y	N	Is your dizziness is constant? If it comes in attacks, how often? _____
Y	N	Are you completely free of dizziness between attacks?
Y	N	Do you have any warning that the attack is about to start?
Y	N	Is the dizziness provoked by head/ body movement? If so, which direction? _____
Y	N	Is the dizziness worse at any particular time of the day? If so, when? _____
Y	N	Do you know of anything that will precipitate an attack? What? _____
Y	N	Do you know any possible cause of your dizziness? _____
Y	N	My dizziness is intense but only lasts for seconds or minutes.
Y	N	I get dizzy when I turn over in bed.
Y	N	I get short-lasting, spinning dizziness that happens when I bend down to pick something up.
Y	N	I get short-lasting, spinning dizziness that happens when I go from sitting to lying down.
Y	N	I can trigger my dizzy spells by placing my head in certain positions.
Y	N	I have had a single severe spell of spinning dizziness that lasted for a few hours to a day.
Y	N	After a big episode of dizziness, I could not walk for days without falling over.

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Patient Neurodiagnostic Intake

PATIENT NAME: _____ DATE: _____

Y	N	I had a spell of spinning dizziness that lasted for hours after I had a cold, virus, or flu.
Y	N	I had hearing loss in one ear at the same time I had the long episode of spinning dizziness.
Y	N	I have spells where I get dizzy, and it is difficult for me to breathe.
Y	N	I feel dizzy all of the time.
Y	N	I am anxious most of the time.
Y	N	I am bothered by patterns, screens, e.g. supermarkets.
Y	N	When I cough or sneeze, I get dizzy.
Y	N	I get dizzy when I strain to lift something heavy.
Y	N	When I speak, my voice sounds abnormally loud to me.
Y	N	My dizziness is provoked with head movements (UP / DOWN and/or RIGHT / LEFT)
Y	N	My head is heavy like a bowling ball.
Y	N	I have a headache that is in or starts in the back of my head
Y	N	When I sit up from lying down, or stand up from sitting, I experience a few seconds of dizziness
Y	N	I have had a single severe spell of seeing the world spinning around me that lasted days or weeks.
Y	N	I have spells where I get dizzy and also have irregular heartbeats (palpitations).
Y	N	I hear my voice more loudly in one ear compared to the other.
Y	N	I am unsure of my footing when I walk outside.
Y	N	I get dizzy when I am in open spaces and have nothing to hold onto.
Y	N	have a roaring sound in one ear only before or during a dizziness attack.
Y	N	I am depressed much of the time.
Y	N	There are times when I get dizzy and also have a headache.
Y	N	My hearing gets worse in one ear before or during a dizziness attack.
Y	N	I had a single constant spell of spinning dizziness that lasted longer than 2-3 days.
Y	N	When I get a headache, I am very sensitive to sound (I try to find a quiet place to rest).
Y	N	I get headaches that hurt so badly that I am completely unable to do my daily activities.
Y	N	I have a sensation of dizziness or imbalance daily or almost daily.
Y	N	My vision changes before a headache begins.
Y	N	I am unsteady on my feet all the time.
Y	N	When I get a headache I am very sensitive to light (I try to find a dark room to rest).

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Patient Neurodiagnostic Intake

PATIENT NAME: _____ DATE: _____

Balance & Fall Symptoms (Circle Y for Yes, Circle N for No)

Y N Have you fallen in the past year?

If YES: How many times? _____ Where? INSIDE THE HOME / OUTSIDE THE HOME

If NO: Have you experienced "near falls" but you caught yourself? YES / NO

Y N Are you afraid of falling?

Y N Are you veering / leaning while walking? If YES: Which direction? RIGHT / LEFT / BOTH

Y N Do you have neuropathy, numbness, or tingling in your legs?

Y N Has your exercise decreased? If YES, approximately when? _____

Y N Do you have any orthopedic injuries? If YES, please explain:

_____

Pertinent Medical History:

Y N Are your blood sugar, blood pressure, and thyroid levels well controlled?

Y N Do you have any known eye/ vision issues?

If YES, please explain:

_____

Y N Do you have hearing loss?

If YES, which ear? RIGHT / LEFT / BOTH

Y N Do you wear hearing aids?

Y N I am experiencing ear PAIN / RINGING / DRAINAGE / FULLNESS (*circle all that apply*)

If YES: Which ear? RIGHT / LEFT / BOTH (*circle one*)

If Applicable: Female Hormonal History

(*Circle one*) Are you PRE / PERI / POST - Menopausal?

Y N Did you have a hysterectomy? If YES, when? _____

Y N Have you had any changes to your contraceptives? If YES, when? _____

Y N Do you have known hormonal imbalance? If YES, are you being treated for this issue? YES / NO