Treasure Coast Audiology, Inc.

2340 NE Dixie Hwy
Jensen Beach, FL 34957

7550 US1
Vero Beach, FL 32967

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 #:__________

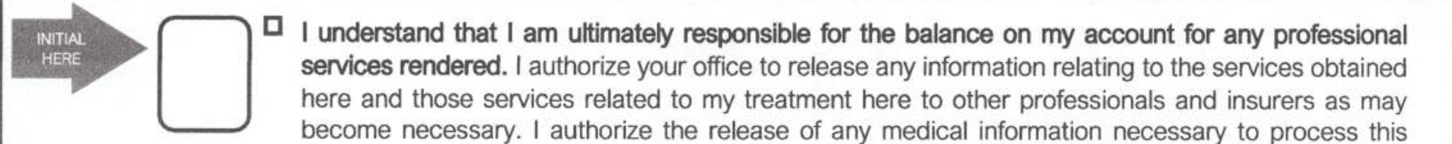
Acknowledgement of Payment (Check All That Apply)

☐ Cash ☐ Check ☐ VISA ☐ Mastercard ☐ Discover

Primary Insurance:__________ ID#:__________ Group #:__________

Primary Card Holder Name: __________ Primary Card Holder Date of Birth:____/____/____

Secondary Insurance Name:__________ ID#:__________ Group #:__________



☐ **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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Medical History

Patient Name:______________________ Date of Birth: ___/___/___ Today's Date ___/___/___

HEIGHT __________ WEIGHT __________

What is the main purpose of your visit today?

____

____

How did you hear about Treasure Coast Audiology? ______________________

Please answer the following hearing-related questions:

1. Do you think you have any hearing loss? ☐ YES ☐ NO (If your answer was NO, please skip down to questions #2.)
   a. In which ear do you feel you hear better? ☐ RIGHT ☐ LEFT ☐ BOTH (SAME)
   b. When did you first notice your hearing loss? ______________
   c. Did your hearing loss occur suddenly or gradually? ______________
   d. What do you think caused your hearing loss? ______________
   e. Does your hearing fluctuate? ☐ YES ☐ NO
      i. How often does it fluctuate? ______________
      ii. When does it fluctuate? ______________

2. Have you ever had a hearing test/ screening before? ☐ YES ☐ NO (If NO, skip to #3)
   a. When was your last hearing test? ______________
   b. Where was your last hearing test performed? ______________
   c. Did the test identify hearing loss? ☐ YES ☐ NO
   d. Were hearing aids recommended? ☐ YES ☐ NO

3. List the listening environments you experience the most difficulty in, for example, group settings or using the telephone.
   a. ______________
   b. ______________
   c. ______________

4. Do you have constant or intermittent ringing, buzzing, or other noises (tinnitus) in your ears? ☐ YES ☐ NO
   a. In which ear? ☐ RIGHT ☐ LEFT ☐ BOTH
   b. Is one ear worse than the other? Which one? ☐ RIGHT ☐ LEFT
   c. How long have you been experiencing these noises? ______________
   d. Have these noises changed recently? ☐ YES ☐ NO
   e. Have you consulted a medical professional regarding tinnitus? ☐ YES ☐ NO
      If so, whom have you consulted? ______________
   f. Does background noise block out the noise in your ears? ☐ YES ☐ NO
   g. Do you use any of the following? Please mark all that apply.
      ☐ Caffeine/ Coffee ☐ Aspirin ☐ Cigarettes ☐ Alcohol ☐ Sodium/ Salt

5. Do you experience dizziness or light-headedness? ☐ YES ☐ NO
   a. Describe your symptoms: ______________
   b. When did the dizziness/ light-headedness begin? ______________
   c. How frequent are the episodes of dizziness/ light-headedness? ______________
   d. Have you consulted a professional regarding this? ☐ YES ☐ NO

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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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Hearing Aid Questionnaire

PATIENT NAME: ______________________________ DATE: ____________________

Noise Exposure:

Please indicate whether you have been exposed to any of the following types of high intensity noise:

Military Service	☐ YES	☐ NO	How long? ____________
Factory/ Construction/ Farming	☐ YES	☐ NO	How long? ____________
Gunshots/ Fireworks	☐ YES	☐ NO	How long? ____________
Woodworking/ Power tools	☐ YES	☐ NO	How long? ____________
Loud Music	☐ YES	☐ NO	How long? ____________
Yard Equipment	☐ YES	☐ NO	How long? ____________
Other types of Machinery	☐ YES	☐ NO	How long? ____________
Any other Loud Noise Exposure	☐ YES	☐ NO	How long? ____________

Do you wear hearing protection for the times you are exposed to loud noises?

☐ NO ☐ SOMETIMES ☐ ALWAYS

What kind of hearing protection do you use? ______________________________

Prior to this appointment, what experience do you have with hearing aids? (check all that apply)

☐ I have never visited with an audiologist to inquire about hearing aids.

☐ I have visited with an audiologist to gather information regarding my hearing difficulties, but I have not tried or purchased any hearing aids.

☐ I have tried hearing aids but only wear them occasionally or not at all.
Why do you not wear them? ______________________________

☐ I have a hearing aid(s) and wear it/ them regularly on the ☐ left ear ☐ right ear ☐ both ears.

Please rank the following in terms of their importance in a hearing aid.
(1 through 4, with 1 being the most important)

_____Overall Sound Quality _____ Reliability _____Style / Appearance _____Cost

Have you ever had a head injury or a concussion? ☐YES ☐NO

A. Were you knocked unconscious? ☐ YES ☐ NO

B. Did you experience any loss of hearing after the injury? ☐ YES ☐NO

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Hearing Handicap Inventory

PATIENT NAME: ______________________________ DATE: ________________

Please circle YES, SOMETIMES, or NO to each of the following items. Do not skip a questions if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

E-1.	Does a hearing problem cause you to feel embarrassed when meeting new people?	YES	SOMETIMES	NO
E-2.	Does a hearing problem cause you to feel frustrated when talking to members of your family?	YES	SOMETIMES	NO
S-3.	Do You have difficulty hearing when someone speaks in a whisper?	YES	SOMETIMES	NO
E-4.	Do you feel handicapped by a hearing problem?	YES	SOMETIMES	NO
S-5.	Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	YES	SOMETIMES	NO
S-6.	Does a hearing problem cause you to attend religious services less often than you would like?	YES	SOMETIMES	NO
E-7.	Does a hearing problem cause you to have arguments with family members?	YES	SOMETIMES	NO
S-8.	Does a hearing problem cause you difficulty when listening to TV or radio?	YES	SOMETIMES	NO
E-9.	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	YES	SOMETIMES	NO
S-10.	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?	YES	SOMETIMES	NO

For Audiologist Use Only:

TOTAL SCORE: _______

SUBTOTAL E: _______

SUBTOTAL S: _______

0-8 NO REFERRAL
10-24 MODERATE HANDICAP
26-40 REFER