ADVANCED
AUDIOLOGY & HEARING AIDS, LLC

New Patient Intake

Name: First: _____ Middle: _____ Last: _____

By what name would you like to be addressed?: _____ Spoken Language (check one): ☐ English ☐ Spanish ☐ Other

Street Address: _____ City/State: _____ Zip Code: _____

Preferred Phone #: _____ ☐ Home ☐ Cell ☐ DO NOT LEAVE A DETAILED MESSAGE

Secondary Phone #: _____ ☐ Home ☐ Cell ☐ DO NOT LEAVE A DETAILED MESSAGE

Email Address: _____ ☐ CHECK IF EMAIL IS PREFERRED METHOD OF CONTACT

Date of Birth: _____ Social Security Number: _____ Gender (check one): ☐ Male ☐ Female

If you would prefer **NOT** to receive educational newsletters via mail or email, please check here ☐

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Name of Spouse (if applicable): _____ Birthdate: _____

If child, please list the name of the custodial parent or guardian: _____

Employer: _____ (check one): ☐ Part-time ☐ Full-time ☐ Retired

Occupation: _____ Work Phone #: _____

Emergency Contact: _____ Relationship to Patient: _____ Phone #: _____

Referring Physician Name: _____ Phone #: _____

Who referred you to our clinic? _____

What is your primary complaint today? ☐ Hearing loss ☐ Tinnitus ☐ Other Please explain: _____

When did your symptom(s) begin? _____

Do your symptom(s) fluctuate? _____ If yes, when is it the worst? _____

Is your symptom(s) worse in one ear? _____

Which is your better ear? ☐ RIGHT ☐ LEFT ☐ UNSURE

Have you ever had a hearing test? _____ When and where? _____

Were there any recommendations? _____

Jerrilyn Frasier, Au.D., L-SLP/A

1503 Goodwin Rd., Suite 205, Ruston, LA 71270
Phone: (318) 251-1572

MEDICAL HISTORY

Have you had any of the following? If yes, any within last 90 days? (check all that apply)

☐ EAR DRAINAGE ☐ EAR PAIN ☐ HOLE IN EARDRUM ☐ UNILATERAL HEARING LOSS

☐ DIZZINESS ☐ HEAD TRAUMA ☐ SUDDEN HEARING LOSS ☐ EAR SURGERY ☐ EAR FULLNESS

Describe: _____

Have you been examined by a doctor in the past six months? ☐ YES ☐ NO

Are you taking blood thinning medication? ☐ YES ☐ NO

How did your hearing loss develop? ☐ Gradually ☐ Suddenly ☐ Past 90 days

How many years have you experienced hearing difficulty? _____

Have you ever had wax removed from your ears by a doctor? ☐ YES ☐ NO

Have you ever had ear infections? ☐ YES ☐ NO

Have you ever been exposed to loud noise in your lifetime? ☐ YES ☐ NO

Do you know the cause of your hearing loss? ☐ YES ☐ NO

If yes, please explain: _____

Have you experienced any of the following?

☐ DEFORMITY OF THE EAR ☐ ACUTE OR RECURRING DIZZINESS ☐ FLUCTUATING HEARING LOSS

☐ PAIN IN YOUR EARS ☐ SINUS/ALLERGY PROBLEMS ☐ RINGING OR NOISES IN YOUR EARS

Have you been diagnosed with having any of the following?

☐ MENIERE'S DISEASE ☐ CHOLESTEATOMA ☐ ACOUSTIC NEUROMA

☐ OTOSCLEROSIS ☐ DIABETES ☐ HEART DISEASE

☐ HIGH BLOOD PRESSURE ☐ ALZHEIMER'S ☐ DEMENTIA

Describe: _____

Have you ever been treated with chemotherapy or radiation? ☐ YES ☐ NO If yes, for what and when?

_____

Do you suffer from any other illness? ☐ YES ☐ NO Describe: _____

NOISE HISTORY

Check all that apply: ☐ Occupational ☐ Military ☐ Recreational

If yes, explain: _____

Do you use hearing protection? _____

COMPLETE THIS SECTION ONLY IF YOU ARE SCHEDULED FOR A <u>HEARING AID EVALUATION</u>

Where do you have trouble hearing? ☐ Radio/TV ☐ Groups ☐ Job ☐ Noise ☐ Large Rooms ☐ Church

Do you hear but have difficulty understanding? ☐ YES ☐ NO

Do voices sound blurry, like people mumbling? ☐ YES ☐ NO

Do you hear some people better than others? ☐ YES ☐ NO IF YES, DESCRIBE: _____

Do others complain that you play the TV too loudly? ☐ YES ☐ NO

Do you find yourself asking people to repeat themselves? ☐ YES ☐ NO

Do you have difficulty knowing from which direction sounds are coming? ☐ YES ☐ NO

Do you avoid social events because of your hearing difficulty? ☐ YES ☐ NO

If a hearing loss is discovered, are you ready for help? ☐ YES ☐ NO

Do you use an amplifier? ☐ YES ☐ NO Can you use the telephone? ☐ YES ☐ NO Can you hear it ring? ☐ YES ☐ NO

Have you ever used assistive listening devices? ☐ YES ☐ NO

Do you use a cellphone or Bluetooth device? ☐ YES ☐ NO

Do you avoid social situations you enjoy because of your hearing problem? ☐ YES ☐ NO

Do you rely on others to translate? ☐ YES ☐ NO

Do you have any physical disabilities that make it difficult to manipulate small controls? ☐ YES ☐ NO

Which hand do you write with? ☐ RIGHT ☐ LEFT

Have you ever tried to use a hearing aid? ☐ YES ☐ NO

Brand: _____

Serial Number(s) Right:_____ Left: _____

When/Where purchased _____

What are your priorities in treating your hearing loss? _____

PLEASE RATE THE FOLLOWING ITEMS #1 THROUGH #6 AS THEY PERTAIN TO YOUR HEARING.

_____ Understanding speech better

_____ Comfort

_____ Inconspicuous appearance (size)

_____ Service

_____ Performance in noisy surroundings

_____ Price of hearing instruments

COMPLETE THIS SECTION IF YOU CURRENTLY USE HEARING AIDS

Do you have difficulty with:	**With amplification**	**Without amplification**
Understanding when two or more people are talking?	☐ YES ☐ NO	☐ YES ☐ NO
Understanding at a distance?	☐ YES ☐ NO	☐ YES ☐ NO
Understanding while on the telephone?	☐ YES ☐ NO	☐ YES ☐ NO
Understanding when your back is to the speaker?	☐ YES ☐ NO	☐ YES ☐ NO
Understanding when listening to the TV?	☐ YES ☐ NO	☐ YES ☐ NO

Do your hearing aids:

Make sound loud enough?	☐ YES ☐ NO
Make some sounds too loud?	☐ YES ☐ NO
Make your voice sound hollow or unnatural?	☐ YES ☐ NO
Make sounds tinny or metallic?	☐ YES ☐ NO
Whistle or give feedback?	☐ YES ☐ NO
Make your ears sore?	☐ YES ☐ NO

OFFICE USE ONLY:

_____

_____

_____

PLEASE SIGN YOUR INITIALS BY EACH STATEMENT TO CONFIRM YOUR AGREEMENT AND SIGN AND DATE AT THE BOTTOM.

CONSENT FOR AUDIOLOGICAL SERVICES

_____ I consent to receive audiological services at Advanced Audiology & Hearing aids, LLC. This consent encompasses audiological procedures including, but not limited to, diagnostic testing and rehabilitative treatment. I understand that this consent form will be valid and remain in effect as long as I receive audiological care at Advanced Audiology & Hearing aids, LLC.

RECEIPT OF NOTICE OF PRIVACY PRACTICES

_____ A copy of our Notice of Privacy Practices is displayed on the wall next to our front desk. If you prefer a written copy one will be made available to you upon request.

SIGN HERE

Patient or Guardian Signature: _____ Date: _____

Original to be maintained in patient's permanent medical record.