

Welcome to Davis Family Hearing
AUDIOLOGY CASE HISTORY FORM

Name: _____

Date: _____

Presenting Problem

1. What is your primary complaint about your ears or hearing? _____
2. If you have a hearing loss, how long have you noticed this? _____
3. What do you think caused your hearing problem? _____
4. Which is your worse ear (if they are different): Left/ Right
5. Do you have difficulty understanding: TV: Yes___ No___ Telephone: Yes___ No___ In groups: Yes___ No___

History

1. Have you had your hearing tested before? Yes___ No___ If yes, when and where: _____
2. Any drainage from the ear within the past 90 days? Yes___ No___ Left/ Right/ Both
3. Have you experienced any dizziness, balance problems, or falls? Yes___ No___ If yes, circle which one(s) apply.
4. Have you had any pain/discomfort in your ears within the past 90 days: Yes___ No___ Left/ Right/ Both
5. Have you ever lost hearing in one ear suddenly? Yes___ No___ Left/ Right
6. Do you have any noises or ringing in your ears? Yes___ No___ Left/ Right/ Both
If yes, is it: Constant___ Intermittent___ When did you first notice it? _____
7. Have you received any medical or surgical treatment for hearing loss? Yes___ No___ Left/ Right/ Both
8. Have you ever been exposed to loud noise? Military Occupation/Job Recreational
9. Is there a history of hearing loss in your immediate family? Yes___ No___ Who: _____
10. Have you ever worn a hearing aid(s)? Yes ___ No ___
11. Medical problems (check all that apply):
Infectious disease ___ Diabetes ___ Heart problems ___ Head injury ___ Cancer ___
High blood pressure ___ Headache ___ Kidney failure ___ Stroke ___
Other (please explain): _____
12. Name of Primary Care Physician: _____
Phone number of Primary Care Physician: _____
City of Primary Care Physician: _____
13. Have you used a tobacco product (cigarette, cigar, smokeless tobacco) one or more times in the past 24 months?
No___ Yes___ How often have you used a tobacco product in the past 24 months? _____
What type(s) of products have you used? _____
14. Do you have any allergies (silicone, latex, vinyl, etc.)? _____
15. Do you utilize pacemaker and/or defibrillator? Yes ___ No ___

Medications: _____

Insurance Authorization

I authorize the release of any information by Davis Family Hearing to determine insurance benefits and assignment of benefits for payment of services provided to me. I request that my insurance carrier make payments to Davis Family Hearing. I understand that not all office services and cost of an aid are covered by my insurance and that any unpaid balance not covered by my policy will be payable by me. I hereby agree to the terms of payment as discussed at the time services are rendered and in accordance with Davis Family Hearing insurance policy.

Patient's Signature _____ Date _____

Permission for Treatment

I hereby voluntarily consent to audiological care and audiological diagnostics by Davis Family Hearing deemed advisable and necessary in the diagnosis and treatment of my hearing condition.

I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

Patient's Signature _____ Date _____

Patient Authorization Record

I authorize that my personal information, hearing healthcare treatment and financial information may be assessed by and disclosed to the individuals listed. (Doctor, family member, caregiver, friend)

Name	Relation
_____	_____
_____	_____
_____	_____
_____	_____

Receipt of Notice of Privacy Policy

I have received a copy of Davis Family Hearing's Privacy Policies and understand its contents. (A full copy of our HIPAA is available upon request).

Patient's Signature _____ Date _____