Evergreen Speech
& Hearing Clinic, Inc.
Transforming Lives Through Improved Communication Since 1979 www.everhear.com

Audiology ◆ Hearing Testing ◆ VRA ◆ VNG/VEMP ◆ OAE ◆ BAER/ECochG ◆ Hearing Aids ◆ Cochlear/Bone Implants ◆ Tinnitus ◆ CAPD ◆ EHDDI
Speech-Language Pathology ◆ Language ◆ Voice ◆ Accent Modification ◆ Autism ◆ Evaluation & Treatment ◆ Pediatric & Adults

Patient Information Form

Patient Information

Patient Name: ______________________________________ Date of Birth: ___/___/______ Age: _________
Last *First* *MI* *mo* *day* *year*

Gender: __________ Email Address: ____

Address: ______________________________ City: ________________ State: _______ Zip Code: _______

Cell Phone: _________________ Home Phone: ___________________ Work Phone: ___________________

Referred by: _______________________________ Family Physician: ________________________________

Other specialists involved in care: ____

Primary reason(s) for today's visit: ____

____

Person Responsible for Account: ____
Last *First* *MI*

Insurance Information

Primary Insurance Company:____

Subscriber's Name: ____________________________ Subscriber's Date of Birth: ______________________

Group Number: _________________________________ ID Number: ________________________________

Secondary Insurance Company:____

Subscriber's Name: _____________________________ Subscriber's Date of Birth:____________________

Group Number: __________________________________ ID Number_______________________________

Assignment and Release

Please Note: We will happily bill your primary insurance carrier and secondary insurance carrier, if applicable.

Assignment and Release: I hereby authorize Evergreen Speech and Hearing Clinic, Inc. to release any information required by appropriate agencies or insurance companies. I also authorize my insurance benefits to be paid directly to Evergreen Speech and Hearing Clinic. I am financially responsible for any unpaid balance.

Signature of Patient or Legal Guardian: _____________________________________ Date: ______________

Kirkland Office ◆ 12333 NE 130th Lane, #430 ◆ Kirkland, WA 98034 ◆ 425.899.5050 Fax - 425.899.5054
Bellevue Office ◆ 1800 116th Ave NE, #103 ◆ Bellevue, WA 98004 ◆ 425.454.1883 Fax - 425.454.2036
Redmond Office ◆ 8301 161st Ave NE, #208 ◆ Redmond, WA 98052 ◆ 425.882.4347 Fax - 425.883.0043

Adult Hearing History

General Information

Name: ______________________________

Date of Birth: ______________ Age: ________ Today's Date: ______________

Referral: ______________ Email: ______________

Chief Complaint, or reason for visit: ______________________________

Present Symptoms:

Hearing Loss: ❑ Both Ears ❑ Right Only ❑ Left Only ❑ None

If yes, when did your hearing loss first begin? ______________________________

Have you had your hearing evaluated previously? ❑ YES ❑ NO

Has your hearing been tested since your last visit? ❑ YES ❑ NO

If yes, when and where? Any changes? ______________________________

Do you know what caused your hearing loss? ______________________________

Was it sudden, gradual, or does it fluctuate? ______________________________

Hearing Instruments: ❑ Both Ears ❑ Right Only ❑ Left Only ❑ None

If yes, brand: ______________ Model: ______________

Year obtained: ______________ Where obtained:______________

Advantages: ______________ Limitations: ______________

Dizziness / Unsteadiness? ❑ YES ❑ NO

If yes, when did it first occur? ______________________________

Is it constant or periodic? ______________ If periodic, how often does it occur? ______________

What elicits an attack? ______________________________

Feeling of Fullness/ Pressure in ears: ❑ Both Ears ❑ Right Only ❑ Left Only ❑ None

Please describe your symptoms: ______________________________

If yes, when did the fullness first occur? ______________________________

Is it constant or periodic? ______________________________

If periodic, how often does it occur? ______________________________

Tinnitus (noise or ringing in ears): ❑ Both Ears ❑ Right Only ❑ Left Only ❑ None

If yes, when did it first occur? ______________ Is the sound constant or periodic? ______________
Please describe the sound: ______________ Does it vary? ______________

Continued on the next page

Patient Name: ____________________
Date of Birth: ____________________

Tinnitus continued

Is the sound distressing to you? ❑ YES ❑ NO

If yes, describe: ____________________

Does anything alleviate or exacerbate the tinnitus? ____________________

Would you like more information on our tinnitus management program? ❑ YES ❑ NO

Ear Infections/Middle Ear Problems:

History of middle ear problems? ❑Both Ears ❑Right Only ❑Left Only ❑None

If yes, please describe previous infections or other problems: ____________________

When was your last ear infection? ____________________

Previous treatments? ____________________

Ear pain or discharge? ❑ YES ❑ NO

If yes, please describe: ____________________

Have you seen a physician or ear specialist in the last six months? ❑ YES ❑ NO

If yes, name of doctor(s): ____________________

List significant findings or treatments: ____________________

____

Noise History: (since last visit)

Do you have any military experience? ❑ YES ❑ NO

If yes, how long? ____________________

Branch of service: ____________________

Responsibilities: ____________________

Have you been exposed to excessive noise in the past 14 hours? ❑ YES ❑ NO

If yes, please describe: ____________________

Did you wear ear protection during the entire noise exposure? ❑ YES ❑ NO

Occupational Noise: (employers where you were exposed to loud noise levels)

	Employer	City	Duties	Length of Service	Ear Protection (Y/N)
1.					
2.					
3.					
4.					

Recreational Noise:

Have you ever used or participated in any of the following? (Check all that apply)

❑ Chainsaw ❑ Dirt bike or loud RV ❑ Firearms ❑ Motorcycles

❑ Lawn equipment ❑ Wood working equipment ❑ Loud music ❑ Other: ____________________

Patient Name: ____________________
Date of Birth: ____________________

When in high noise areas, I use hearing protection (please circle):

NEVER 10% 20% 30% 40% 50% 60% 70% 80% 90% ALWAYS

Type of hearing protection used (brand and model): ____________________

Family History of Hearing Loss

Relation to you: Cause: Age when acquired loss:

1. ____________________
2. ____________________
3. ____________________

General Health History

Question	YES	NO
Any prior major illnesses or injuries? Please describe below.	❑ YES	❑ NO
Any prior operations/surgeries? Please describe below.	❑ YES	❑ NO
Have you undergone anesthesia in the past five years? Please describe below.	❑ YES	❑ NO
Any prior hospitalizations or treatments? Please describe below.	❑ YES	❑ NO
Any recent fever or weight loss? Please describe below.	❑ YES	❑ NO

Social Impact of Hearing Ability

Question	YES	NO
Do you avoid social occasions because you have difficulty hearing?	❑ YES	❑ NO
Do you find yourself having to ask people to repeat themselves?	❑ YES	❑ NO
Do you sometimes hear words but do not understand?	❑ YES	❑ NO
Do you have difficulty understanding people in noisy places?	❑ YES	❑ NO
Have you been told that you speak loudly?	❑ YES	❑ NO
Do others complain of the TV being too loud?	❑ YES	❑ NO
Are some voices easier to understand than others?	❑ YES	❑ NO
Do you find loud sounds bothersome?	❑ YES	❑ NO

Describe your areas of primary hearing difficulty: ____________________

Patient Name: ____________________
Date of Birth: ____________________

Medications

Please list all medications you are currently taking (including vitamins, supplements):

Name	Dosage	How Often	Route (i.e. oral)

Patient Name: ____________________
Date of Birth: ____________________

Systems History

Please check all that apply:

Ears, Nose, Throat and Mouth
- ❑ Hearing loss
- ❑ Consistent ear infections
- ❑ Placement of PE tubes (when? __________)
- ❑ Skin tags or pits near the ears
- ❑ Struggle with hearing in noisy places
- ❑ **No Concern**
- ❑ Other: ____________________

Nose
- ❑ Chronic congestion
- ❑ Frequent sinus infections
- ❑ Trouble breathing through nose
- ❑ **No concern**
- ❑ Other: ____________________

Throat
- ❑ Painful swallowing
- ❑ Pain or discomfort after talking
- ❑ Hoarseness
- ❑ Frequent throat clearing
- ❑ Feeling of something 'stuck' in throat
- ❑ **No concern**
- ❑ Other: ____________________

Mouth
- ❑ Difficulty chewing
- ❑ Coughing frequently while eating
- ❑ Constant dry mouth
- ❑ No concern
- ❑ Other: ____________________

Cardiovascular
- ❑ Chest pain or discomfort
- ❑ Shortness of breath with exertion
- ❑ **No concern**
- ❑ Other: ____________________

Psychiatric
- ❑ Anxiety or stress
- ❑ Depression
- ❑ Sleep problems
- ❑ **No concern**
- ❑ Other: ____________________

Vision
- ❑ Nearsighted
- ❑ Farsighted
- ❑ Astigmatism
- ❑ **No Concern**
- ❑ Other: ____________________

Visual Processing
- ❑ Blurred vision
- ❑ Double vision
- ❑ Difficulty tracking
- ❑ Objects moving while trying to focus
- ❑ Dyslexia
- ❑ **No concern**
- ❑ Other: ____________________

Respiratory
- ❑ Asthma
- ❑ Apnea/Dyspnea
- ❑ Shortness of breath
- ❑ Frequent episodes of pneumonia, bronchitis, or other infections
- ❑ Tobacco Use Yes No
- ❑ **No Concern**
- ❑ Other: ____________________

Neurological
- ❑ Dizziness
- ❑ Frequent headaches
- ❑ Weakness
- ❑ Tremors
- ❑ Seizures
- ❑ Memory loss
- ❑ Poor attention
- ❑ History of brain injury or concussions
- ❑ **No concern**
- ❑ Other: ____________________

Skin
- ❑ Rashes
- ❑ Acne
- ❑ Eczema
- ❑ **No concern**
- ❑ Other: ____________________

Systems History (Cont'd.)

Please check all that apply:

Musculoskeletal

- ❑ Muscle / joint pain
- ❑ Back pain
- ❑ Scoliosis
- ❑ **No concern**
- ❑ Other: ____________________

Gastrointestinal/Genitourinary

- ❑ Heartburn or re lux
- ❑ Frequent nausea / vomiting / diarrhea
- ❑ Constipation
- ❑ Nighttime urination
- ❑ Kidney problems
- ❑ **No concern**
- ❑ Other: ____________________

Allergies

- ❑ Seasonal allergies
- ❑ Food allergies
  Details: ____________________
- ❑ Medication allergies
  Details: ____________________
- ❑ **None**
- ❑ Other: ____________________

Motor Development

Fine Motor

- ❑ Poor handwriting
- ❑ Trouble grasping small objects
- ❑ Trouble opening or closing screw-lid containers
- ❑ Trouble coordinating vision with hand movements (e.g. putting a puzzle together)
- ❑ **No concern**
- ❑ Other: ______________________________

Gross Motor

- ❑ Trouble balancing
- ❑ Falls often
- ❑ Easily trips over objects
- ❑ No concern
- ❑ Other: ____________________

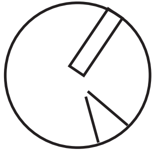
Previous Diagnosis

- ❑ ADD
- ❑ ADHD
- ❑ Autism
- ❑ Asperger's Syndrome
- ❑ Cerebral Palsy
- ❑ Down Syndrome
- ❑ Mental Retardation
- ❑ OCD
- ❑ Cancer (please indicate which type)
  ____
- ❑ **No concern**
- ❑ Other: ______________________

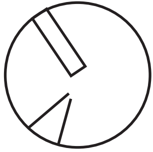
Reviewed: ________________

For Audiologist's Use Only

Otoscopic Inspection



Right Ear



Left Ear

Active drainage observed	❑ YES	❑ NO
Visible Congenital or traumatic deformity	❑ YES	❑ NO
Visible evidence of significant cerumen	❑ YES	❑ NO
Air-bone gap of 15dB (.5, 1, or 2KHz)	❑ YES	❑ NO

Other pertinent information:

Summary:

Recommendations:

❑ Medical Clearance: ______________________________

❑ Rescission Rights: ______________________________

❑ Physician Letter: Dr. ______________________________

❑ Hearing Instruments Initiated: ______________________________

Additional Notes:

Audiologist Signature: ______________________________

Reviewed: ____________________

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