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:_____ Primary Care Physician: _____

Other specialists involved in care: _____

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

_____

Insurance Information

Person Responsible for Account: _____
Last First MI

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: _____

Balance Assessment (ENG/ VNG)

Patient Information

You have been scheduled for a Balance Assessment at Evergreen Speech & Hearing Clinic. The test protocol is made up of a number of subtests that examine the effectiveness and interaction of your vestibular system (the inner ear), and screens the somatosensory (flex and pressure sensors in your feet), and vision system contribution to your overall stability and balance. This will help your doctor determine which system may be contributing to your specific symptoms, and give direction for treatment. The procedure is simple and painless, and requires 1.5 hours to complete.

Please arrive early to your appointment, or take a moment ahead of time to fill out the following **Balance Assessment History** form.

During the test, recording disks will be taped to your face near each eye and in the middle of your forehead (ENG) or you will be wearing an infrared camera on a facemask (VNG). You will be instructed to look at objects, and move your body and head in various positions. Small amounts of cool and warm air will also be delivered into your ear canals to evaluate the symmetry of response for each vestibular (inner ear) structure. This last procedure will result in a short duration turning sensation, but will only last a minute or two, with little or no lasting effects. You will be able to drive following the test, with a 15-20 minute rest period.

Certain substances can influence the body's response to this test, reducing its value and validity. Please **DO NOT TAKE** any of the following for a period of at least **48 hours**:

- Anti-nausea medication (Dramamine, Compazine, Borine, Marezine, Vontrol, Phenergan, Thorazine, etc.)
- Anti-vertigo medication (Antivert, Ruvert, Meclizine, etc.)
- Tranquilizers (Valium, Librium, Atarax, Vistaril, Equanil, Miltown, Triavil, Xanax, Serax, Etrafon, Darcovet, Diazepan, etc.)
- Narcotics and Barbituates (Codeine, Demerol, Dilaudid, Morphine, Percodan, Phenaphen, etc.)
- Sedatives (Nembutal, Seconal, Dalmane, Doriden, Placidyl, Quaalude, Butisol, Feldene, or any other sleeping pills)
- Antihistamines (Chlor-Trimeton, Dimetane, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Seldane, or any over the counter cold remedy)
- Alcohol in any quantity (including beer, wine, or any type of medicine containing alcohol)
- If you have any questions about your present medications (not listed) please consult your physician or call this clinic.

CONTINUE USING HEART MEDICINE, BLOOD PRESSURE MEDICATION, INSULIN, SEIZURE MEDICATIONS OR ANY MEDICATION NOT DESCRIBED IN THE LIST ABOVE.

For your comfort we also recommend:

- A light meal is allowed.
- No drinking, or smoking for two to four hours prior to testing.
- No caffeine (coffee, tea, or cola) after midnight the day before testing.
- Wearing comfortable loose fitting clothes.
- If applicable, bring contacts and glasses.

PLEASE DO NOT WEAR EYE MAKE-UP this will impact the ability of the camera to detect eye movements.

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BALANCE ASSESMENT PATIENT HISTORY (ENG/VNG)

Name: _____
Last First MI

Date of Birth:_____ Today's Date: _____

Hearing and Health History:

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? _____

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

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

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:_____

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 circle which best reflect the percentage of time you are aware of your tinnitus:

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

Please describe the sound:_____ Does it vary? _____

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

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

If yes, when did the fullness first occur? _____

Is it constant or periodic? _____

If periodic, how often does it occur? _____

Ear pain or discharge? □YES □NO

If yes, please describe: _____

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? _____

Please describe your symptoms:_____

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? _____

Other ear surgeries: _____

Have you ever had any of the following conditions?

YES	NO		YES	NO	
□	□	Ear surgery?	□	□	Arthritis?
□	□	Skin tags on or near the ear?	□	□	Diabetes?
□	□	Holes or pits on or near the ear?	□	□	Patches of different colored skin?
□	□	Other ear malformations?	□	□	Bones that break easily?
□	□	Vision loss?	□	□	Fainting spells?
□	□	Difficulty seeing at night?	□	□	Learning impairment?
□	□	Retinitis Pigmentosa (RP)?	□	□	High blood pressure?
□	□	Eye surgery?	□	□	Head injury/ unconsciousness?
□	□	Two different colored eyes?	□	□	Mumps?
□	□	White patch of hair?	□	□	Scarlet Fever?
□	□	Cleft palate?	□	□	Measles?
□	□	Holes or cysts in neck?	□	□	Meningitis?
□	□	Heart disease or defect?	□	□	Allergies?
□	□	Kidney disease or infection?	□	□	Cancer?
□	□	Chemotherapy?	□	□	Other? _____

Please list anyone in your family who had hearing loss prior to 40 years old and their relationship to you: _____

_____

_____

Noise History

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

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: _____

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): _____

Balance and Dizziness History
When you are having symptoms, do you experience any of the following situations?

YES	NO		YES	NO	
□	□	Lightheadedness	□	□	Pressure in the head
□	□	Swimming sensation in the head	□	□	Nausea
□	□	Blacking out	□	□	Headache
□	□	Loss of consciousness	□	□	Vomiting
□	□	Objects spinning or turning around you	□	□	You are spinning or turning while outside objects remain stationary

Loss of balance while walking:
□veering to the right
□veering to the left

Tendency to fall:
□to the right
□to the left
□backward
□forward

When did the symptoms first occur? _____

YES	NO	
□	□	My dizziness is constant
□	□	My dizziness is in attacks
		If yes, how often and how long do they last? _____
□	□	Do you have any warning that it is about to occur?
□	□	Are you completely free of dizziness between attacks?
□	□	Does the dizziness occur only in certain positions?
□	□	Do you have trouble walking in the dark?
□	□	When you are dizzy, must you support yourself when standing?
□	□	If you have tinnitus, does your tinnitus change with your dizziness?
□	□	Do you get dizzy after exertion or overwork?
□	□	Were you exposed to any irritating fumes at the onset of dizziness?
□	□	Do you know of any possible cause of your dizziness?
		If yes, please describe: _____
		Do you know anything that will:
□	□	Stop your dizziness or make it better?
□	□	Make your dizziness worse?
□	□	Precipitate an attack?

Have you ever experienced any of the following symptoms?

Constant	Episodes	NO	
□	□	□	Double vision
□	□	□	Numbness of face or extremities
□	□	□	Blurred vision or blindness
□	□	□	Weakness/ clumsiness in arms or legs
□	□	□	Confusion or loss of consciousness
□	□	□	Difficulty with speech
□	□	□	Tingling around mouth
□	□	□	Difficulty swallowing
□	□	□	Spots before eyes (floaters)

YES	NO	
□	□	Did you get new glasses recently?
□	□	Do you get dizzy when you have not eaten for a long time?
□	□	Do you have allergies?
□	□	Have you ever injured your head or neck?
□	□	Do you use tobacco in any form?
□	□	Do you use alcohol?

If yes, how often and how many drinks? _____

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Systems History

Ears, Nose, Throat, and Mouth

Ears
- ☐ 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

Nose
- ☐ Chronic congestion
- ☐ Frequent sinus infections
- ☐ Trouble breathing through nose
- ☐ No concern

Throat
- ☐ Painful swallowing
- ☐ Pain or discomfort after of talking
- ☐ Hoarseness
- ☐ Frequent throat clearing
- ☐ Feeling of something 'stuck' in throat
- ☐ No concern

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

Acuity
- ☐ Nearsighted
- ☐ Farsighted
- ☐ Astigmatism
- ☐ No concern

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
- ☐ Trouble achieving adequate breath support
- ☐ No concern
- ☐ Other: _____

Neurological
- ☐ Dizziness
- ☐ Frequent headaches
- ☐ Weakness
- ☐ Tremors
- ☐ Seizures
- ☐ Memory loss
- ☐ Poor attention
- ☐ History or brain injury or concussions
- ☐ No concern
- ☐ Other: _____

Skin
- ☐ Rashes
- ☐ Acne
- ☐ Eczema
- ☐ No concern
- ☐ Other: _____

Musculoskeletal
- ☐ Muscle/ joint pain
- ☐ Back pain
- ☐ Scoliosis
- ☐ No concern
- ☐ Other: _____

Gastrointestinal/ Genitourinary
- ☐ Heartburn or reflux
- ☐ 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 (i.e. putting a puzzle together)
- ☐ No concern

Gross Motor
- ☐ Trouble balancing
- ☐ Falls often
- ☐ Easily trips over objects
- ☐ No concern
- ☐ Other: _____

Previous Diagnoses

Please check all previous diagnoses.
- ☐ ADD
- ☐ ADHD
- ☐ Autism
- ☐ Asperger's Syndrome
- ☐ Cerebral Palsy
- ☐ Downs Syndrome
- ☐ Mental Retardation
- ☐ OCD
- ☐ No concern
- ☐ Other: _____

Patient Name: _____
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Medications

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

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