



Patient Information Form

Patient Information

Patient Name: Last First MI Date of Birth: mo day year Age: 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:



Patient Name: _____
Date of Birth: _____

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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.

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.

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, Diazepam, 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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General Information

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: _____



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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?

Table with 4 columns: YES, NO, YES, NO. Rows include conditions like Ear surgery, Arthritis, Skin tags, Diabetes, Holes or pits, Patches of different colored skin, etc.

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



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- Motorcycles, Loud music, Lawn equipment, Other, Wood working equipment

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 Lightheadedness, Swimming sensation in the head, Blacking out, Loss of consciousness, Objects spinning or turning around you
YES NO Pressure in the head, Nausea, Headache, Vomiting, 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, 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?, Do you know anything that will: Stop your dizziness or make it better?, Make your dizziness worse?, Precipitate an attack?



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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: _____

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Medications

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

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