everhear.com

Evergreen Speech & Hearing Clinic, Inc.

Managing your hearing, speech, and balance needs since 1979

Bellevue Office
1800 116th Ave NE #103
Bellevue, WA 98004
F: 425.454.2036
P: 425.454.1883

Kirkland Office
12333 NE 130th Ln #430
Kirkland, WA 98034
F: 425.899.5054
P: 425.899.5050

Redmond Office
8301 161st Ave NE #208
Redmond, WA 98052
F: 425.883.0043
P: 425.882.4347

Patient Information and Insurance Form

Patient Information

Patient Name: _____ Date of Birth: _____ Age: ____ M F
Last *First* *MI*

Address:_____ City:_____ State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Cell#: _____

Referred By:_____ Primary Care Physician: _____

Reason for Visit: _____Email Address:_____

Person Responsible For Account

Name:_____

Address:_____ City:_____ State:_____Zip:_____

Home Phone:_____ Work Phone:_____ Employer:_____

Insurance

Insurance Company:_____ Subscriber:_____

Group #:_____ ID #:_____

Address:_____

Assignment and Release

Please Note: We will happily bill your Primary Insurance Carrier. Please forward appropriate information to your Secondary Insurance.

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 and I am financially responsible for any unpaid balance.

Signature of Patient or Guardian:_____ Date:_____

ID Checked:* □ *yes* □ *no

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Balance Assessment Patient Instructions

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 attached **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.

Balance Assessment (ENG/VNG)
Patient History

Patient Name: _____ BD: _____ Date: _____

Referring Physician: _____ Others Needing Report: _____

I. Primary Symptom(s): _____

_____

II. Hearing and Health History

Hearing Loss:

Has your hearing been tested (if so, where and when)? _____

Do you have a hearing loss? ❑ Yes ❑ No

If so: When did your hearing loss first begin? _____

Do you know what caused your hearing loss? _____

Has your hearing changed? (i.e. sudden, gradual, fluctuating) _____

Do you have a better hearing ear? _____

Hearing Aids: Both Ears Right Only Left Only N/A

Make: _____

Model: _____

Style: _____

Year: _____

Tinnitus (Noise in ears): Both Ears Right Only Left Only N/A

Describe the sound: _____

When did it first occur? _____

Is the sound constant or periodic? _____

If periodic, how often does it occur? _____

Is the sound distressing to you? If yes, describe: _____

Feeling of Fullness: Both Ears Right Only Left Only N/A

When did the fullness first occur? _____

Constant or periodic? _____

If periodic, how often does it occur? _____

Ear Infections/Middle Ear Problems: Both Ears Right Only Left Only N/A

Describe condition: _____

Previous treatments? _____

Have you ever had any of the following conditions. Circle Yes or No and describe.

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

Please list all medications that you are currently taking:_____

_____

Family History of Hearing Loss

Please list anyone who had a hearing loss prior to aged 40 years, and their relationship to you:

1._____

2._____

3._____

Noise History

Have you ever worked around hazardous noise?_____ YES NO

If yes, please list employers below:

Employer	City	Duties	Years of Service	Ear Protection
1.				YES NO
2.				YES NO
3.				YES NO

When in high noise areas, I use hearing protection:

0% (Never) 20% 40% 60% 80% 100% (Always)

Type of hearing protection used (brand and model)_____

Do you have any military experience?_____ YES NO

If yes, in what branch did you serve and when?_____

What were your responsibilities in the military?_____

Were you in a combat situation? (describe)_____

Was hearing protection utilized?_____ YES NO

Do you have any noisy hobbies? _____ YES NO

Chain Saw Dirt bike or loud RV Firearms Loud Music

Lawn Equipment Wood Working Equipment Other Noise Exposure_____

Was hearing protection utilized?_____ YES NO

II. Balance and Dizziness History

When you are having symptoms, do you experience any of the following sensations?

Yes	No	
❑	❑	Lightheadedness
❑	❑	Swimming sensation in the head
❑	❑	Blacking out
❑	❑	Loss of consciousness
❑	❑	Objects spinning or turning around you
❑	❑	You are spinning or turning while outside objects remain stationary
❑	❑	Headache
❑	❑	Nausea or Vomiting
❑	❑	Pressure in the head
		Loss of balance while walking:
❑	❑	Veering to the right
❑	❑	Veering to the left
		Tendency to fall:
❑	❑	To the right
❑	❑	To the left
❑	❑	Backward
❑	❑	Forward

Please check appropriate box and fill in the blanks.

When did the symptoms first occur? _____

Yes	No	
❑	❑	My dizziness is *CONSTANT*
❑	❑	My dizziness is in *ATTACKS*
		If attacks, How Often? _____
		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?
❑	❑	Does the noise change with 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? _____

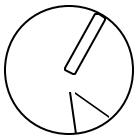
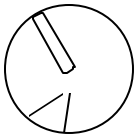
Have you ever experienced any of the following symptoms?

Yes	No			
❑	❑	Double vision	Constant	Episodes
❑	❑	Numbness of face or extremities	Constant	Episodes
❑	❑	Blurred vision or blindness	Constant	Episodes
❑	❑	Weakness/clumsiness in arms or legs	Constant	Episodes
❑	❑	Confusion or loss of consciousness	Constant	Episodes
❑	❑	Difficulty with speech	Constant	Episodes
❑	❑	Tingling around mouth	Constant	Episodes
❑	❑	Difficulty with swallowing	Constant	Episodes
❑	❑	Spots before eyes	Constant	Episodes

Please check the appropriate box.

Yes	No	
❑	❑	Did you get new glasses recently?
❑	❑	Do you tend to get upset easily?
❑	❑	Do you get dizzy when you have not eaten for a long time?
❑	❑	Is your dizziness connected with your menstrual period (if appropriate)?
❑	❑	Do you have allergies?
❑	❑	Have you ever injured your head or neck?
❑	❑	Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, etc.) _____
❑	❑	Do you use tobacco in any form?
❑	❑	Do you use alcohol? How Much? _____

For Audiologist's Use Only

Otoscopic Inspection	Summary:
 Right Ear  Left Ear	Recommendations:
	Additional Notes:

Audiologist Signature