LG Audiological Enterprises, LLC

Audiological Services (Main Office)
601 Ellis AVE, Lufkin, TX 75904
(936) 632-2252

All About Hearing
2703 W Cuthbert AVE, Midland, TX 79701
(432) 689-2220

Central Texas Hearing Center
1320 Wonder World DR, #107, San Marcos, TX 78666 (512) 667-7921

Central Texas Hearing Center
1927 Lohman's Crossing Rd., Ste 203, Lakeway, TX 78734
(512) 640-2999

ADULT CASE HISTORY

Name:_____ Age:_____ Date of Birth:_____ Date:_____

Physician:_____ ☐ Fax Physician Report

☐ Email Patient Report Email Address:_____

** All contact information, including e-mail address, will be used strictly for issues related to today's visit and any necessary future contact. It will not be disclosed to outside sources beyond the scope of our patient privacy policy.

TO BE COMPLETED BY AUDIOLOGIST ONLY:

☐ HI RECOMMENDATION REQUIRED R Make/Model:_____ SN=_____DOP:_____

☐ MEDICAL CLEARANCE REQUIRED L Make/Model:_____ SN=_____DOP:_____

☐ UPGRADE FORM ☐ PRIOR AUTHORIZATION REQUIRED FROM INSURANCE

EAR & HEARING HISTORY

Known Hearing Loss? ☐Yes ☐No
☐Right ☐Left ☐Both
How long? _____
☐Gradual? ☐Sudden? ☐Fluctuating?

Past Ear Surgery? ☐Yes ☐No
☐Right ☐Left ☐Both
Describe: _____

Recent Ear Pain? ☐Yes ☐No
☐Right ☐Left ☐Both
Describe: _____

Recent Ear Drainage? ☐Yes ☐No
☐Right ☐Left ☐Both
Describe: _____

Tinnitus (ringing/other noises in ears)? ☐Yes ☐No
*If yes, please answer more questions on 2nd page.

Dizziness/Balance problems? ☐Yes ☐No
Does the room spin? ☐Yes ☐No
How long have you had problem? _____
How frequently does it occur? _____
Duration of an episode? _____

Family History of Hearing Loss? ☐Yes ☐No
Who? _____

Full/plugged sensation ☐Yes ☐No
☐Right ☐Left ☐Both
How long? _____

EXCESSIVE NOISE EXPOSURE

☐ Construction ☐ Engines (i.e. Auto/Boat/Motorcycle/Skimobile) ☐ Explosions ☐ Factory

☐ Farming ☐ Fire/Police Dept. ☐ Gunfire Military ☐ Gunfire Occupational ☐ Gunfire Recreational ☐ Heavy Equipment

☐ Logging Lumber Industry ☐ Loud Music: Amplified/Live ☐ Mining ☐ Power Tools ☐ Printing

☐Transportation (i.e. Airplane/Boat/Train/Truck) Duration? _____

☐ Other: _____ When? _____

OTHER MEDICAL HISTORY

☐Allergies ☐HIV/AIDS
☐Cancer ☐Kidney Disease
☐Cerebral Palsy ☐Meningitis
☐Diabetes ☐Multiple Sclerosis
☐Head Injury ☐Mumps
☐Heart Attack ☐Stroke
☐High Blood Pressure ☐Other communicable disease: _____

Other Significant Health Issues:	List Medications or ☐Bring List

HEARING LOSS ASSESSMENT

Hearing Handicap Inventory	YES	Sometimes	NO
1. Does your hearing problem cause you to feel embarrassed?	☐	☐	☐
2. Does your hearing problem cause you to feel frustrated when talking to family?	☐	☐	☐
3. Do you have difficulty hearing when someone speaks in a whisper?	☐	☐	☐
4. Do you believe your hearing problem has affected work or similar situations?	☐	☐	☐
5. Does your hearing problem cause you difficulty when visiting friends or family?	☐	☐	☐
6. Does your hearing problem cause you to avoid large group situations?	☐	☐	☐
7. Does your hearing problem cause you to have arguments with friends or family?	☐	☐	☐
8. Does your hearing problem cause you difficulty when listening to TV or radio?	☐	☐	☐
9. Does your hearing problem hamper your personal or social life?	☐	☐	☐
10. Does your hearing problem cause you difficulty when in a noisy situation like a restaurant or party?	☐	☐	☐

Please list four specific <u>goals</u> for improving your hearing:

1. _____ 3. _____

2. _____ 4. _____

If you have worn hearing aids before, please answer the following:

HEARING AID HISTORY

How long have you worn hearing aids? _____

Where did you purchase them? _____

Were they purchased through Private Insurance, Self-Pay, or Medicaid? _____

How satisfied are you with your hearing aid(s) in the following situations?

At home, one-on-one conversations	☐ Good	☐ OK	☐ Poor
In background noise (i.e. restaurants)	☐ Good	☐ OK	☐ Poor
On the Telephone	☐ Good	☐ OK	☐ Poor
On a cellular telephone	☐ Good	☐ OK	☐ Poor
Riding in the car	☐ Good	☐ OK	☐ Poor
At Work	☐ Good	☐ OK	☐ Poor
Television	☐ Good	☐ OK	☐ Poor
In a large room	☐ Good	☐ OK	☐ Poor

Are you here to replace your hearing aids if something better is available? ☐Yes ☐Maybe ☐No

If you answered "yes" that you have tinnitus (ringing or other sounds in your ears), please answer the following:

TINNITUS ASSESSMENT

<u>Description of your tinnitus</u>

What does it sound like?

☐ R ☐L Ringing ☐R ☐L Roaring ☐ R ☐L Rushing

☐ R ☐L Hissing ☐R ☐L Pulsating ☐ R ☐L Warbling

☐ R ☐L Musical ☐R ☐L Other:

How often do you hear it?

☐ R ☐L Rarely ☐R ☐L Occasionally ☐ R ☐L Constantly

Duration:

☐R ☐L Rare ☐R ☐L Occasional ☐ R ☐L Constant

Loudness:

☐ R ☐L Very Loud ☐ R ☐L Loud ☐ R ☐L Present

<u>How Does Your Tinnitus Affect You?</u>

Make you irritable or nervous?	☐Yes ☐ No
Make you tired or stressed?	☐Yes ☐ No
Affect your sleep habits?	☐Yes ☐ No
Make it difficult to relax?	☐Yes ☐ No
Make it difficult to concentrate?	☐Yes ☐ No
Interfere with your work?	☐Yes ☐ No
Interfere with social activities?	☐Yes ☐ No
Make you depressed?	☐Yes ☐ No
Affected you otherwise?	☐Yes ☐ No

Describe: _____