

AUDIOLOGY CASE HISTORY FORM

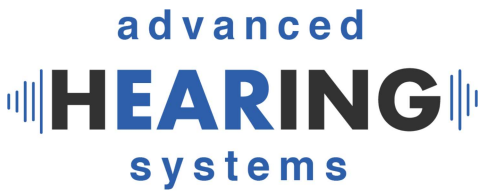
Name: _____ Date: _____ Date of Birth: _____

Presenting Problem:

1. What is your chief complaint for coming in today? _____
2. How long have you noticed your hearing loss (if applicable)? _____
3. What do you think caused your hearing problem? _____
4. Which ear is worse? Left _____ Right _____ Same _____
5. Do you have difficulty understanding:
 - a. TV: Yes_No_ Telephone: Yes_No_ Conversation: Yes_No_ In Noise: Yes_No_

History:

1. Have you had your hearing tested before? Results? _____
2. Any present ear drainage within the last 90 days? Yes___No___ Which ear? _____
3. Have you ever experienced any dizziness/vertigo or balance issues? _____
4. Have you ever experienced any pressure/fullness (aural fullness) in your ears?
 - a. Yes___No___ Left___Right___
5. Have you had ear pain/discomfort in the past 90 days? _____
6. Do you experience any ringing/buzzing (tinnitus) in your ears?
 - a. Yes___No___ Intermittent___Constant___ Bothersome___Non-bothersome___
7. Have you ever had any medical/surgical treatment related to your ears/hearing? _____
8. Have you ever been exposed to excessive loud noise (i.e. military, job)? _____
9. Are you a previous hearing aid user? Yes___No___ Left/Right/Both Brand? _____



Patient Authorization for Release and Disclosure of Protected Health Information

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

As required by the Privacy Regulation, this practice may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I authorize Melissa Moore-Schmitt and Brianna Schmitt, audiologists, at Advanced Hearing Systems LLC in Swansea, Illinois to release the following information to:

Patient Health Information authorized to be disclosed

Audiogram and associated reports, along with pertinent progress notes or other information in my file.

For the specific purpose of (describe in detail):

Medical Records, Insurance, Reviews of Files

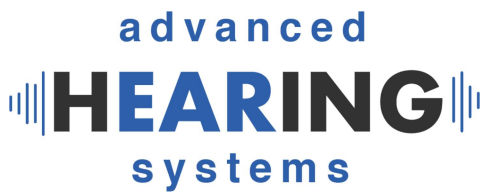
I understand that the information disclosed above may be re-disclosed to additional parties and may no longer be protected. I understand that I have the right to:

- Revoke this authorization by sending written notice to this office
- Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization
- Inspect a copy of Patient Health Information being disclosed under federal law.
- Refuse to sign this authorization
- Receive a copy of this authorization
- Restrict what is disclosed with this authorization

I understand that if I do not sign this document, it will not affect my treatment, payment, enrollment in a health plan, or eligibility for benefits. It is my choice to provide authorization of my protected patient health information to benefit my health's interest.

Signature of Patient or Patient's Authorized Person

Date



NOTICE OF PRIVACY PRACTICES

All patient information in the office of Advanced Hearing Systems LLC, 4933 Benchmark Centre Drive, Suite B in Swansea, Illinois is considered to be confidential. Patient information is released as needed to provide adequate audiological treatment. Any other release of private patient information requires a release of information specific to the party. The information is released to and signed by the patient.

The patient has the right to review his/her own patient information/file when requested.

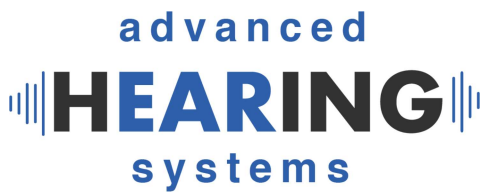
Healthcare providers are required by law to protect patient health information.

The policy of Advanced Hearing Systems LLC is to follow-up quickly on any privacy issues by way of Melissa Moore Schmitt and Brianna Schmitt, audiologists. These privacy policy guidelines are effective June 2020. Any changes to this policy will be included in the future handouts.

I acknowledge that I have received and reviewed the written Notice of Privacy Policies of Advanced Hearing Systems LLC, 4933 Benchmark Centre Drive, Suite B in Swansea, Illinois.

Signature

Date



TINNITUS HANDICAP INVENTORY

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

The purpose of the scale is to identify the problems your tinnitus may be causing you. Circle “**Yes**”, “**Sometimes**”, or “**No**” for each question. Please do not skip a question.

- | | |
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| 1. Because of your tinnitus, is it difficult to concentrate? | Yes/Sometimes/No |
| 2. Does the loudness of your tinnitus make it difficult for you to hear people? | Yes/Sometimes/No |
| 3. Does your tinnitus make you angry, frustrated, anxious and/or confused? | Yes/Sometimes/No |
| 4. Do you complain a great deal about your tinnitus? | Yes/Sometimes/No |
| 5. Does your tinnitus cause issues with sleeping? | Yes/Sometimes/No |
| 6. Does your tinnitus interfere with your ability to enjoy social activities? | Yes/Sometimes/No |
| 7. Does your tinnitus interfere with your daily routine and/or job? | Yes/Sometimes/No |
| 8. Do you feel that your tinnitus problem has placed stress on your relationship with family members and/or friends? | Yes/Sometimes/No |
| 9. Do you find it difficult to focus your attention away from your tinnitus? | Yes/Sometimes/No |
| 10. Do you feel that you have no control over your tinnitus? | Yes/Sometimes/No |
| 11. Does your tinnitus make you lethargic? | Yes/Sometimes/No |
| 12. Does your tinnitus make you depressed? | Yes/Sometimes/No |
| 13. Do you feel that you can no longer cope with your tinnitus? | Yes/Sometimes/No |
| 14. Does your tinnitus get worse when you are under stress? | Yes/Sometimes/No |
| 15. Does your tinnitus make you feel insecure? | Yes/Sometimes/No |