COMPREHENSIVE INTAKE

FLORIDA AUDIOLOGY ASSOCIATES

PATIENT DEMOGRAPHICS

First name:_____ Last name:_____ Middle initial:____

Suffix: (None / I / II / Sr / Jr) Title: (Mr. / Mrs. / Ms. / Dr) Gender: (M / F / N/A)

DOB:_____ SSN:_____

Marital status: (Single / married / divorced / widowed / legally separated / other)

Employment status: (Full time / part time / retired / unemployed / self-employed / student)

Race: (White / American Indian or Alaskan Native / Asian / Black or African American / Native Hawaiian or other Pacific Islander / Not specified) Ethnicity:(Hispanic or Latino/ none/ not specified)

Employer: _____Employer phone number: _____

Employer address:_____ / _____ / _____ / _____
street city state zip

Home address (No PO box):_____ / _____ / _____ / _____
street city state zip

Primary language:_____ Highest level of completed education:_____

REFERRAL SOURCE

How did you hear about our office? _____

INSURANCE

Primary insurance company: _____ Policy# _____

Group# _____ Phone number:_____

Subscriber name: _____ Relationship to patient:_____

Secondary insurance company: _____ Policy# _____

Group# _____ Phone number:_____

Subscriber name: _____ Relationship to patient:_____

Tertiary insurance company: _____ Policy# _____

Group# _____ Phone number:_____

Subscriber name: _____ Relationship to patient:_____

PATIENT CONTACT INFORMATION

Home phone:_____ Cell phone:_____

Email:_____ Consent to text: (YES / NO) Consent to email: (YES / NO)

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EMERGENCY CONTACT INFORMATION

First name:_____ Last name:_____

Relation: _____ Phone:_____

Home address (No PO box):_____ / _____ / _____ / _____
street city state zip

PHYSICIAN INFORMATION

Primary care provider:_____ Phone: _____

Fax: _____ Date of last visit: _____

Address:_____ / _____ / _____ / _____
street city state zip

HEARING LOSS (HHIE)

Date of last hearing exam: _____ Examiner:_____

Do you experience hearing loss? (YES / NO) Which ear?: (LEFT / RIGHT / BOTH)

Onset of hearing loss: (SUDDEN / GRADUAL / FLUCTUATING) Date of sudden loss: _____

When did you first notice your hearing loss? _____

Do you know the cause of your hearing loss? _____

Do you struggle on the phone? (YES / NO) Which ear do you use to talk on the phone? (LEFT / RIGHT / BOTH)

Have you ever worn a hearing aid? If yes, please describe your experience:

_____

_____

_____

If currently wearing hearing instruments, please check any of the following concerns:

- ☐ Sounds are too loud
- ☐ Sounds are too soft
- ☐ Sudden sounds are painful
- ☐ Discomfort while wearing
- ☐ Sounds are tinny of metallic
- ☐ Difficulty cleaning instrument
- ☐ Trouble with finding direction of sounds
- ☐ Battery life
- ☐ Unnatural sound quality
- ☐ Trouble understanding in quiet
- ☐ Wind noise
- ☐ Feedback or whistling
- ☐ Difficulty changing the battery
- ☐ Repair issues
- ☐ Other:

_____

_____

- ☐ Trouble understanding in noise
- ☐ Not satisfied with appearance
- ☐ Do not like the sound of your own voice

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Patient initials: _____ Date: _____

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Do you feel handicapped by a hearing problem?

Sometimes

Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?

Sometimes

Does a hearing problem cause you to attend religious services less often than you would like?

Sometimes

Does a hearing problem cause you to have arguments with family members?

Sometimes

Does a hearing problem cause you difficulty when listening to TV or radio?

Sometimes

Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?

Sometimes

Does your hearing loss make you feel embarrassed when meeting new people?

Sometimes

Does your hearing loss cause frustration when talking to members of your family?

Sometimes

Have you experienced any of the following major medical conditions (please check all that apply):

- ☐ HIV / AIDS
- ☐ Appetite change
- ☐ Arthritis
- ☐ Blood disorders
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cognitive decline
- ☐ Shingles
- ☐ Diabetes
- ☐ Diptheria
- ☐ Encephalitis
- ☐ Fatigue
- ☐ Genetic disorders
- ☐ Headaches
- ☐ Head injury
- ☐ Heart problems
- ☐ High blood pressure
- ☐ High fevers
- ☐ Influenza
- ☐ Malaise
- ☐ Malaria
- ☐ Measles
- ☐ Meningitis
- ☐ Mumps
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Tonsilitis
- ☐ Typhoid
- ☐ Vascular problems
- ☐ Other: _____

Please check all medical symptoms that apply:

- ☐ Eyes (pain, blurred vision)
- ☐ Nose, throat, or mouth (trouble swallowing, nose bleeds, dental issues, pain)
- ☐ Cardiovascular (hypertension, chest pain, swelling, palpitations)
- ☐ Respiratory (shortness of breath, cough, wheezing)
- ☐ Gastrointestinal (nausea, vomiting, weight changes, diarrhea, pain)
- ☐ Musculoskeletal (joint pain, swelling, recent trauma)
- ☐ Neurological (numbness, headaches, seizure, muscle weakness)
- ☐ Psychiatric (depression, anxiety, compulsions)
- ☐ Endocrine (frequent urination, hot flashes)
- ☐ Hemotologic / lymphatic (bleeding gums, bruising, swollen glands)
- ☐ Allergic / immunologic (hives, asthma, itching, immune deficiency

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Patient initials: _____ Date: _____

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- Additional comments related to general health:

_____

_____

Any history of significant illness or hospitalization?

_____

_____

Current medications:

Drug:_____
Dosage: _____
Frequency: _____

Drug:_____
Dosage: _____
Frequency: _____

Drug:_____
Dosage: _____
Frequency: _____

Drug:_____
Dosage: _____
Frequency: _____

Drug:_____
Dosage: _____
Frequency: _____

Drug:_____
Dosage: _____
Frequency: _____

Drug:_____
Dosage: _____
Frequency: _____

Drug:_____
Dosage: _____
Frequency: _____

Allergies:

_____

_____

Recreational drug use: (YES / NO / SOMETIMES)

Drug: _____ Frequency: _____ times per day / week / month

Drug: _____ Frequency: _____ times per day / week / month

Drug: _____ Frequency: _____ times per day / week / month

Tobacco use: (Sometimes Frequency: _____ (cigarettes / packs) per day / week

Alcohol use: Sometimes Frequency: _____ drinks per day / week / month

I attest that the information provided wherein is true to the best of my knowledge at the time of completion. _____
I acknowledge my responsibility to update my provider with any changes in contact information, insurance, or medical history prior to each appointment. _____

Print:_____ Signature:_____

Date: _____ Relationship to patient: _____