AUDIOLOGY ASSOCIATES HEARING CENTER

101 Margaret Lane, Suite D, Grass Valley, CA 95945
Phone: (530) 272-2247
Fax: (530) 272-4120
www.GrassvalleyHearing.com
Sol Barros Lic# AU1699

Patient Intake/Tinnitus

Name _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____ Gender ☐ M ☐ F

Your Mailing Address _____
Street City State Zip

Primary Phone _____ ☐ Home ☐ Cell ☐ Work ☐ Other

Health History

What is your primary reason for coming in today? _____

Do you have a better hearing ear? ☐ R ☐ L ☐ Either

Have you experienced a sudden/progressive hearing loss in the last 90 days? ☐ R ☐ L ☐ Both ☐ Neither

Have you had any ear surgery?	☐ Yes	☐ No	If yes, please explain. _____	
Do you suffer from ear pain or discomfort?	☐ Yes	☐ No	Do you have any pressure in your ears?	☐ Yes ☐ No
Do you have any fullness/pressure in your ears?	☐ Yes	☐ No	Do you notice ringing/sounds in your ears?	☐ Yes ☐ No
Do you have dizziness/vertigo?	☐ Yes	☐ No	Do you have a history of ear drainage?	☐ Yes ☐ No
Have you been exposed to excessive noise in the last 16 hours?	☐ Yes	☐ No		

Please review and check the following boxes:

☐ I give permission to this practice to release information, verbal or written, contained in my medical record and other related information to my insurance company, health care providers, assignees and/or beneficiaries and all other related persons.

☐ I allow for voice messages from this practice to be left on any provided phone number.

☐ I acknowledge that I have had the opportunity to review a copy of Audiology Associate's privacy notice. (Available in our office and on our website.)

☐ I allow the following individuals (e.g. spouse/family members/caregivers) to be allowed access to my information regarding my hearing and ongoing treatments for the duration of my care, unless Audiology Associates is notified otherwise.

_____

☐ I hereby authorize all benefits for charges of examination and/or treatments requested to be paid to Audiology Associates Hearing Center. Verification of insurance coverage obtained over the phone does not guarantee payment. I have read this statement and accept full financial responsibility for all medical charges incurred by my dependents or me for services rendered by Audiology Associates Hearing Center.

_____ _____
Signature of Patient, Parentor or Legal Guardian Date

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Tinnitus Questionnaire

Please answer the following groups of questions:

Have you ever:

Had any noisy jobs? ☐ Yes ☐ No
Had any noisy hobbies or home activities? ☐ Yes ☐ No
Used solvents, thinners or alcohol based cleaners? ☐ Yes ☐ No

General Hearing Problems

Do you:

Have loose dentures, jaw pain or grinding or clicking sensations in your jaw? ☐ Yes ☐ No
Regularly take aspirin? ☐ Yes ☐ No
Have any feelings of ear pressure or blockage? ☐ Yes ☐ No
Have any difficulties hearing when there is background noise? ☐ Yes ☐ No
Have any difficulties understanding one-on-one conversations? ☐ Yes ☐ No
Have any difficulties hearing the TV? ☐ Yes ☐ No
Have any difficulties hearing on the telephone? ☐ Yes ☐ No
Wear ear protection/earplugs? ☐ Yes ☐ No
If so, how often and under what circumstances?_____
Find external sounds unpleasant or uncomfortable? ☐ Yes ☐ No
If so, please list _____

Effects of Your Tinnitus

Over the past week, what percentage of the time were you aware of your tinnitus? _____%
What percentage of the time was it disturbing? _____%
In which situations do you notice your tinnitus the most? _____
Describe the sound of your tinnitus (hissing, ringing, buzzing, etc.) _____
In which ear does your tinnitus occur? ☐ Left ☐ Right ☐ Both If both, in which ear is it worse? ☐ Left ☐ Right
Is your tinnitus: ☐ constant ☐ comes and goes
Does your tinnitus fluctuate in intensity or loudness? ☐ Yes ☐ No
What makes your tinnitus worse? _____
What makes your tinnitus better? _____
Do you find exposure to moderately loud sounds makes your tinnitus worse? ☐ Yes ☐ No
Does your tinnitus affect your sleep? ☐ Yes ☐ No

How has tinnitus affected your work life?_____
_____
_____

How has tinnitus affected your home life? _____
_____
_____

How has tinnitus affected your social activities? _____
_____
_____

Tinnitus History

When did you first become aware of your tinnitus, and what do you consider to have first started your tinnitus? _____

_____

_____

When did your tinnitus first become disturbing? Any specific situation? _____

_____

_____

Who have you consulted about your tinnitus? _____

What have you been told about your tinnitus? _____

What treatments have you tried for your tinnitus? ☐ None ☐ TRT ☐ Hearing Device ☐ Counseling ☐ Masker ☐ Music Therapy ☐ Other, please describe _____

How successful did you find these treatments? _____

_____

_____

Please rank the auditory problems you experience.

	Not Very Troublesome ▼									Very Troublesome ▼
Hearing Difficulties	1	2	3	4	5	6	7	8	9	10
Tinnitus	1	2	3	4	5	6	7	8	9	10
Sensitivity to Loud Sounds	1	2	3	4	5	6	7	8	9	10

Are you pending any legal action? ☐ Yes ☐ No

List any medications you take for your tinnitus _____

List any other medications you take _____

Have you tried any medications in the past for your tinnitus? _____

Please list any medical evaluations and/or treatments related to your tinnitus (e.g., CT/MRI/psychological evaluation/etc.)

_____

_____

_____