POTOMAC
AUDIOLOGY
Doctorate-level hearing care you can trust

Adult History Form

One Central Plaza
11300 Rockville Pike Suite 105
Rockville MD 20852

187 Thomas Johnson Drive
Suite 3
Frederick, MD 21702

240-477-1010

Name: ___________________________________ Today's Date: _____________

☐ **Female** ☐ **Male** ☐ **Prefer not to specify**

Date of Birth: **Current Age: _____**

Occupation/Profession: __________________________ Retired? Y / N

How did you find us? **Physician referral (name): _____________________**
Current Patient (name):__________________Website:_______________________
Internet search___ Social Media Site____

Contact Information:

Telephone (Home) ___________________ Telephone (Cell) __________________

Email address: ____

Mailing Address: ____

____

How would you like to be contacted about appointment reminders?

Text Message____ Phone Call ________ Email________

We would like a **copy of our findings** sent to your primary care physician to keep them informed of your care. Please provide the contact information:
If you prefer we do not send the results/report, please check here: ______

____

____

Describe the **concerns** you have about your hearing ability:

____

Please rate your hearing/understanding ability for the following 3 situations:

In a quiet room talking with one or two family members or close friends:
1 2 3 4 5 6 7 8 9 10

Can't hear at all **Hear about half** **Hear everything**

In a restaurant talking with two or three family members or close friends:
1 2 3 4 5 6 7 8 9 10

Can't hear at all **Hear about half** **Hear everything**

At a party with music playing and talking with many family/friends/acquaintances:
1 2 3 4 5 6 7 8 9 10

Can't hear at all **Hear about half** **Hear everything**

Hearing and Balance History

1. Have you had your **hearing tested** previously? ☐ Yes ☐ No ☐ Don't recall

   If Yes, please identify the date of the test and the results (if known):

   ____

2. Does anyone in your **family** have a hearing loss? ☐ Yes ☐ No ☐ Don't know
   If Yes, please explain:

____

____

3. Do you currently or have you had a history of **medical problems** with your ears?

   Ear Infections ☐ Yes ☐ No ☐ Not sure

Medications for the ears ☐ Yes ☐ No ☐ Not sure

Ear Surgery ☐ Yes ☐ No ☐ Not sure

Surgery of the head and/or neck ☐ Yes ☐ No ☐ Not sure

Fractures of the head or neck ☐ Yes ☐ No ☐ Not sure

If Yes to any of the above, please explain:

____

____

4. Have you ever been diagnosed with **brain injury** of any kind following trauma to the head from an accident, fall, etc.? ☐ Yes ☐ No ☐ Not sure
   If Yes, please explain:

   ____

5. Are you currently or have you been exposed to **hazardous noise** (heavy equipment, guns, playing music, motorcycles, etc.)? ☐ Yes ☐ No ☐ Not sure
   If Yes, please describe:

   ____

6. Have you or do you currently use **hearing protection** (plugs, muffs, etc.) when exposed to hazardous noise? ☐ Yes ☐ No ☐ Not sure
   If Yes, describe the type used:

____

7. Do you currently use, or have you ever **used hearing aids/**other hearing devices? ☐ Yes ☐ No

8. If Yes, please describe: ______________________________

   ____

9. Do you currently or have you ever experienced **dizziness,** imbalance or vertigo (spinning)? ☐ Yes ☐ No ☐ Don't know
   If Yes, please explain:

   ____

   ____

9. Have you **fallen** because of being dizzy or feeling off-balance? ☐ Yes ☐ No
   If Yes, please explain:
   ____
   ____

10. Have you ever had the **dizziness evaluated** or treated? ☐ Yes ☐ No ☐ N/A
    If Yes, please explain:
    ____

11. Do you have **ringing, buzzing** noises (tinnitus) in your ears

    ☐ Yes ☐ No

    If Yes, explain:
    ____

    If **Yes**, please rate your **<u>awareness</u>** of the ear noise during the day:

1 2 3 4 5 6 7 8 9 10

Mildly aware **Moderately aware** **Aware all the time**

If **Yes**, please rate how **<u>bothered</u>** you are by the ear noise during the day:

1 2 3 4 5 6 7 8 9 10

Mildly bothered **Moderately bothered** **Severely bothered**

Medical History

12. Have you been **diagnosed** with any of the following?

    Diabetes ☐ Yes ☐ No
    If Yes, please describe: ______________________________

    Heart/cardiac condition (including high blood pressure) ☐ Yes ☐ No
    If Yes, please describe: ______________________________

    Skin or other cancer ☐ Yes ☐ No
    If Yes, please describe: ______________________________

Neurological conditions (stroke, dementia, numbness, weakness, etc.)

☐ Yes ☐ No

If Yes, please describe: ____

Vision problems ☐ Yes ☐ No

If Yes, please describe: ____

Do you wear glasses/contacts? ☐ Yes ☐ No

13. Are you taking any medications (prescription, over-the-counter, and/or supplements)?

    ☐ Yes ☐ No

    If Yes, please list:

    _________________________ _________________________

    _________________________ _________________________

    _________________________ _________________________

14. Any other medical issues or concerns at this time? ☐ Yes ☐ No ☐ Not sure

    If Yes, please describe: ____

    ____

    ____

    ____

If you did not bring your insurance cards with you, please ask for an insurance form.
MEDICARE will not pay for **any** testing without a referral.
Your insurance may not cover all your costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for those services. Some costs are covered, however exceed the negotiated rate or allowable rate based on your individual insurance plan. The negotiated rate is the amount Potomac Audiology will be paid by the insurance companies per our contract. This may differ from the allowable amount indicated by your insurance plan.

I understand that I am responsible for my estimated deductible, co-insurance, co-pay, upgrade, and any portion my insurance does not pay.

Signature:____Date:____________

Please bring your insurance cards so we may make a copy

Primary Insurance: Policy Holder

ID Number: Group Number :

Secondary Insurance: Policy Holder:

ID Number: Group Number:

Relationship to Patient if other than "Self":

Date of Birth of Insured: