Pt File #_____
Date:_____

NYCE HEARING CENTER, P.C.

Adult Case History

Name: _____ Date of Birth:_____
Address:_____
City_____ State____ Zip Code: _____
Home Phone: _____ Cell Phone:_____
E-Mail:_____

Who referred you to us?_____

Primary Physician: _____
Address: _____
_____
Phone: _____

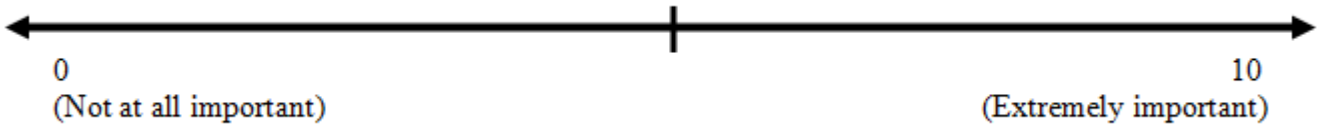
May we send your primary physician results from your appointment? ___ YES ___ NO

What is your primary complaint about your ears or hearing?
_____
_____
_____
_____

Have you ever had a hearing evaluation? _____ YES _____NO
If YES, when and where?_____
What were the results/recommendations?_____

If you have a hearing loss, how long have you noticed this problem?_____

How important is it for you to improve how you hear, understand and communicate with family members and friends RIGHT NOW (mark an X on the line below)



Hearing Health History (Check all that apply):

__ Hearing fine, no difficulties
__ Able to hear, but not clearly
__ Others say I don't hear
__ I have problems hearing the television
__ I have difficulties on the telephone
__ I have problems in groups/noisy listening situations
__ I have difficulties hearing in church and/or large venues

Have you ever lost hearing in one or both ears *suddenly* _____YES _____NO

Do you hear better out of one ear? ___ YES (___ right ___ left) ___ NO
How long has this been occurring?_____

Do you have sounds in your ears (tinnitus) which others don't hear? ___ YES ___ NO
If yes, describe the sounds_____
Is it __ constant __ occasional? In the__ right ear __ left ear or __ both ears?

On a scale of 1 (barely noticeable) to 10 (causes extreme problems), how would you describe the severity of the tinnitus? 1 2 3 4 5 6 7 8 9 10

Do you have a history of ear infections? ___ YES ___ NO
If yes, last ear infection?_____
Usual treatment: _____

Do you have any problems with cerumen (wax)? ___ YES ___ NO
If yes, how often do you have your ears cleaned by a professional? _____

Have you ever had ear surgery? ___ YES ___ NO
What type of ear surgery?_____

Have you had any drainage from the ears in the past 90 days? _____YES _____NO

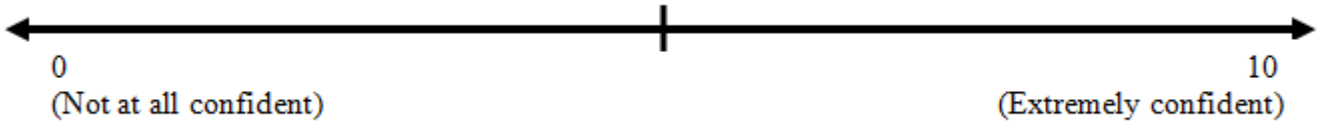
Have you experienced any dizziness, balance problems or falls? _____YES _____NO
If yes, please explain_____
_____

Is there a family history of hearing loss? _____ YES _____NO
If yes, who? _____
If known, why?_____

Do you wear a hearing aid now? ___ YES (___ right ___ left) ___NO
How is it functioning? _____
_____

How would you rate your experience with your current hearing aids on a scale of 1 (NOT GOOD) to 10 (VERY GOOD) 1 2 3 4 5 6 7 8 9 10

How confident are you in your ability to use and take care of hearing aids if they are recommended? (Mark an X on the line below)



In what situations would you most like hearing aids to help you? (If recommended)
_____Conversations with family and friends
_____Watching television
_____Talking on the telephone
_____In the car
_____Places of worship
_____Listening to music
_____In restaurants

What social activities do you engage in routinely? (Meetings, Clubs, Card Games)
_____
_____
_____
_____

Select all that apply:
_____ I am not ready for hearing aids at this time.
_____I have been thinking that I might need hearing aids.
_____I have started to seek information about hearing aids.
_____I am ready to wear hearing aids if they are recommended.
_____I am comfortable with the idea of wearing hearing aids.

Comments or specific questions for the Audiologist:
_____
_____
_____
_____
_____

Noise History

What loud sound have you been exposed to?

__ Firearms
__ Power Tools
__ Farm equipment
__ Motorcycles/Recreational vehicles
__ Factory/Construction Noise
__ Music/Bands
__ Heavy equipment
__ Other: _____

Did/do you wear ear protection in these environments? _____YES _____NO

Are you still exposed to this type of noise? ___ YES ___ NO

Medical History

Please check any of the following that apply…

__ Heart disease
__ Stroke/TIA
__ Diabetes
__ Cancer
__ High blood pressure
__ Depression/Anxiety
__ Auto-immune disorder
__ Kidney or Renal problems
__ Chronic sinus infections
__ Environmental allergies
__ Chemotherapy __Radiation
__ Head trauma
__ Migraine
__ Taking blood thinners

More information about any of the above checked disorders:

_____
_____
_____
_____
_____
_____

Please list your current prescriptions:

Medication	Reason for taking?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

HIPPA AND INSURANCE COMPLIANCE

1. I authorize NYCE Hearing Center, PC to submit charges for any medical procedures completed or products given in their office to my insurance company. Further, I authorize payment of medical benefits to be made directly to NYCE Hearing Center, PC for services rendered. This authorization shall remain in effect until otherwise stated, in writing, by myself.

Signature _____ Date_____

2. I have read and understand NYCE Hearing Center's privacy policies (located on the back of the clipboard)

Signature _____ Date_____

*** If you would like a copy of NYCE Hearing Center's privacy policies that are located on the back of your clipboard, please ask the receptionist and she will be happy to provide you with that information.

3. I authorize Nyce Hearing Center P.C. to contact me through email or text message in regards to my treatment.

Signature _____ Date_____

4. Nyce Hearing Center is authorized to send me information in the future about new products and/or procedures designed to help my hearing.

Signature _____ Date_____