ROCKET HEARING & BALANCE

5 N Maple Avenue, Suite 100
La Plata, Maryland 20646
410-696-3669 ph | 410-695-3769 fax

First visit
Follow-up
Annual check

DIZZINESS QUESTIONNAIRE

Patient's Name _____ Today's Date _____

Describe the purpose of today's visit _____

Describe the first time you felt dizziness and/or imbalance. When did it occur? What else happened?

_____

_____

Describe the most recent time you felt dizziness and/or imbalance. When did it occur? What else happened?

_____

_____

Circle Y for Yes or N for No for each of the following statements about your experience with dizziness and/or imbalance.

Y N It is constant.
Y N It comes and goes.
Y N It is always there, but some times are worse than others.

Y N It lasts a few seconds at a time.
Y N It lasts a few minutes at a time.
Y N It lasts hours at a time.
Y N It lasts days at a time.

Y N It happens when standing or walking.
Y N It happens when I move my head.
Y N It happens when I bend over or look up.
Y N It happens when I get in or out of bed.
Y N It happens when I stand up from a chair.

Y N It makes me feel nauseous.
Y N It makes me feel faint.
Y N It makes me vomit.

What can you do to make the dizziness and/or imbalance stop? _____

How do you feel between episodes? _____

Do you have any co-occuring symptoms?

Y N Hearing loss
Y N Pain or pressure in the ears
Y N Ringing in the ears
Y N Blurred or doubled vision

How active were you before your problem started?

And, how active are you now?

AROUND THE TIME YOUR DIZZINESS AND/OR IMBALANCE STARTED, DID YOU...

Y N	Experience a cold or virus?	Y N	Had not eaten for an extended period of time?
Y N	Incur an accident or head trauma?	Y N	Experience intense stress or anxiety?
Y N	Lose consciousness?	Y N	Participate in heavy lifting?
Y N	Travel by air or swim underwater?	Y N	Experience a headache or migraine?

Other: _____

FALLS HISTORY

Have you fallen in the last year? Y N If yes, when was your last fall? _____

Do you worry about falling? Y N Do you feel unsteady when standing or walking? Y N

DIZZINESS HISTORY

Please check A for Always, S for Sometimes, and N for Never for each question.

		A	S	N
1	Does looking up increase your problem?			
2	Because of your problem, do you feel frustrated?			
3	Because of your problem, do you restrict your travel for business or pleasure?			
4	Does walking down the aisle of a grocery store increase your problem?			
5	Because of your problem, do you having difficulty getting out of or into bed?			
6	Does your problem restrict your participation in social activities, like going to dinner?			
7	Because of your problem, do you have difficulty reading?			
8	Does your problem increase when performing sports activities or household chores?			
9	Because of your problem, are you afraid to leave home without someone with you?			
10	Because of your problem, have you become embarassed in front of others?			
11	Do quick movements of your head increase your problem?			
12	Because of your problem, do you avoid heights?			
13	Does turning over in bed increase your problem?			
14	Because of your problem, is it difficult to do strenuous housework or yardwork?			
15	Because of your problem, are you afraid people will think you are intoxicated?			
16	Because of your problem, is it difficult for you to go for a walk by yourself?			
17	Does walking does a sidewalk increase your problem?			
18	Because of your problem, is it difficult for you to concentrate?			
19	Because of your problem, is it difficult for you to walk around your house in the dark?			
20	Because of your problem, are you afraid to stay at home alone?			
21	Because of your problem, do you feel handicapped?			
22	Has your problem placed stress on relationships with friends and family?			
23	Because of your problem, do you feel depressed?			
24	Does your problem interfere with your job or household responsibilities?			
25	Does bending over increase your problem?			

Are there any other details that you would like to share?

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HEARING HEALTH QUESTIONNAIRE

Patient's Name _____ Today's Date _____

Describe the purpose of today's visit _____

Circle Y for Yes or N for No for each of the following statements about your hearing health.

Do you think you have a hearing loss?	Y N	If yes, which ear?	R L Both	_____
Do family or friends think you have a hearing loss?	Y N			
Do you have difficulty hearing in a group?	Y N			
Do you have difficulty hearing on the telephone?	Y N			
Do you have difficulty hearing the television?	Y N			
Have you ever had earwax removed by a doctor?	Y N	If yes, which ear?	R L Both	_____
Do you have any pain or fullness in your ears?	Y N	If yes, which ear?	R L Both	_____
Do you have any active discharge from your ears?	Y N	If yes, which ear?	R L Both	_____
Have you ever experienced sudden dizziness?	Y N			
Have you experienced long-term dizziness?	Y N			
Do you have any eye or vision difficulties?	Y N			
Have you experienced sudden hearing loss?	Y N	If yes, which ear?	R L Both	_____
Do you have any family history of hearing loss?	Y N			
Do you have any history of loud noise exposure?	Y N			
Have you ever had surgery on your ears?	Y N	If yes, which ear?	R L Both	_____
Do you have any ringing or buzzing in your ears?	Y N	If yes, which ear?	R L Both	_____

When was your last hearing test? _____

Do you currently or have you ever worn hearing aids? Y N If yes, describe them and your experience using them.

_____

_____

What do you enjoy doing in your free time?

_____

Has has your hearing loss limited your ability to enjoy yourself or the company of others?

_____

Was there anything that wasn't covered that you would like to share?

_____

_____

Please check the answer that comes closest to your everyday experience.

A for "Always" or 100% of the time *H for "Half the time" or 50% of the time*

O for "Occasionally" or 25% of the time *N for "Never" or 0% of the time*

		A	H	O	N
1	When I am in a crowded grocery store, I can hear and understand the cashier.				
2	I miss a lot of information when listening to a lecture or listening to a sermon.				
3	Unexpected sounds, like an alarm bell or a smoke detector, are uncomfortable.				
4	I have difficulty hearing conversation when at home with one of my family members.				
5	I have trouble understanding dialogue in a television show or movie.				
6	When I am listening to the news on the radio in the car, and other people in the car are talking, I have trouble hearing the radio.				
7	It is difficult to have a conversation with one person when at dinner with a group.				
8	Traffic noises are too loud.				
9	When I am talking to someone across a big, empty room, I can understand the words.				
10	In a small office setting, interviewing or answering questions, I have difficulty following the conversation.				
11	When I watch a movie in the theater, I can still hear dialogue even if people around me are whispering or opening snacks.				
12	I have difficulty hearing and understanding when having a quiet conversation with a friend.				
13	The sounds of running water in a shower or toilet are uncomfortably loud.				
14	When a speaker is addressing a small group and everyone is listening quietly, I have to strain to understand.				
15	It is hard to understand quiet, private conversation with my doctor when in the exam room.				
16	I can understand conversations even when several people are talking.				
17	The sounds of construction work are uncomfortably loud.				
18	It is hard to understand what is being said at lectures or church services.				
19	I can communicate with others when we are in a crowd.				
20	The sound of a fire engine nearby is so loud that I need to cover my ears.				
21	I can follow the words of a sermon when listening to religious services.				
22	The sound of screeching tires is uncomfortably loud.				
23	I have to ask people to repeat themselves in one-on-one conversation in a quiet room.				
24	I have trouble understanding others when an air conditioner or fan is on in the room.				

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GENERAL MEDICAL HISTORY

Patient's Name _____ Today's Date _____

Describe the purpose of today's visit: _____

When was your last hearing test? _____

Have you ever had ear surgery? _____

Is there any family history of hearing loss? _____

Please indicate if you are experiencing any of the following:

- ☐ Ear pain
- ☐ Ear fullness
- ☐ Ear drainage
- ☐ Dizziness
- ☐ Headache
- ☐ Nausea
- ☐ Sudden loss of hearing
- ☐ Difference in hearing between right and left ear
- ☐ Ringing in one or both ears
- ☐ Prolonged loud noise exposure
- ☐ Sensitivity to sound
- ☐ Changes in vision

Please indicate if you are being treated for any of the following:

- ☐ Ear infection
- ☐ Heart condition
- ☐ Blood disorder
- ☐ Blood pressure
- ☐ Cancer
- ☐ Diabetes
- ☐ Migraine
- ☐ Stroke
- ☐ Seizure
- ☐ Head injury
- ☐ Neurological disorder
- ☐ Other long term illness

Please describe any current or previous experience with hearing aids and/or other hearing assistive devices:

_____

_____

Please descrbe previous surgeries, if any:

_____

_____

_____

_____

_____

Please list current medications below (or, if you carry a copy of your medications list, please provide a copy):

_____

_____

_____

_____

_____

Is there anything else that you would like for us to know before treating you?

_____

_____

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PATIENT INTAKE

Patient's Name _____ Today's Date _____

DOB _____ SSN _____ Gender _____ Age _____

Street Address _____

City _____ State _____ Zipcode _____

Home phone _____ Cell phone _____ Email _____

Preferred method of contact _____

Is it okay to leave reminder messages on your voicemail? Y N

Is it okay to email reminder messages? Y N

Occupation _____ Employer _____

Marital Status _____ Spouse's Full Name _____

Emergency Contact _____ Phone Number _____

Relationship to Patient _____

Primary Care Physician _____ Phone Number _____

Referring Physician _____ Phone Number _____

May we send today's test results directly to your physicians listed above? Y N

How did you hear about our office? _____

INSURANCE INFORMATION Please provide insurance cards upon arrival.

Primary Insurance Company _____	Secondary Insurance Company _____
ID Number _____	ID Number _____
Group Number _____	Group Number _____
Name of Policy Holder _____	Name of Policy Holder _____
Policy Holder's DOB _____	Policy Holder's DOB _____

RESPONSIBLE PARTY FOR BILLING

Responsible Party's Full Name _____

Home Address _____

Phone Number _____ Relationship to Patient _____

PATIENT PRIVACY POLICY

I hereby give consent to Rocket Hearing & Balance to disclose test results to the physician(s) named on the previous page and my personal information disclosed to the insurance company(s) listed on the previous page and their agents for the purpose of obtaining payment for services and determining insurance benefits payable. I understand that I am fianancially responsible for all charges whether or not paid for and/or covered by my insurance company(s). I authorize the use of my signature on all submissions. I understand that I have the option to request a hard copy of the full privacy policy.

Signature _____ Date _____

I hereby authorize Rocket Hearing & Balance to reasonably use and/or disclose my health information to execute treatment, activities of billing and payment, and other healthcare operations as necessary. I understand that my health information specifically identifies me or can be used to identify me. While I understand that this authorization is voluntary, I also understand that if I refuse to consent, services may be withheld from me. I also understand that I have the ability to revoke this consent at any time and the revocation must be received in writing. I further understand that any actions taken by Rocket Hearing & Balance prior to receiving written revocation will not be affected.

Signature _____ Date _____

I hereby authorize Rocket Hearing & Balance to disclose information about my care and/or account to the following:

Spouse		Care Taker	
Primary Care Physician		Other	
Neurologist		Other	
ENT Physician		Other	

Signature _____ Date _____

I hereby authorize payment of medical benefits billed to my insurance to be issued to Rocket Hearing & Balance. I accept responsibility for payment for any services(s) or product(s) provided to me that is or are not covered by my insurance company(s). I also accept responsibility for fees that exceed the payment made by insurance company(s) if Rocket Hearing & Balance does not participate with my insurance or if I otherwise agree in writing. I agree to pay all copayments, coinsurances, and/or deductibles in full at the time services are rendered or upon receipt of invoice by mail.

The above policy will remain in effect for as long as I am under the care of a provider at Rocket Hearing & Balance, or if otherwise notified. My signature represents my review, understanding, and acceptance of the above billing policies.

Signature _____ Date _____

Printed Name _____

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Authorization to Release Information

Patient's Name _____ Today's Date _____

I, the above named patient, hearby authorize Rocket Hearing & Balance, to release and/or receive protected health information, including but not limited to diagnoses, health reports, test results, recommendations, and treatment guidelines for myself or the individual listed below.

Name _____ Date of birth _____

I understand that these permissions may be revoked at anytime by notifying Rocket Hearing & Balance in writing at the address listed above. I understand that the written revocation must be signed and dated with a date that is later than the date on this authorization form. Any revocation will not affect any actions taken before the receipt of the written revocation.

I further understand that this authorization will remain effective from the date of my signature for one full year. I understand that all information will be handled confidentially in compliance with all applicate state and federal laws.

If I have any questions, I understand that I am welcome to contact Rocket Hearing & Balance at the above listed phone number.

_____ _____
Signature of patient/guardian Date

_____ _____
Signature of witness Date