QUALITY HEARING
& AUDIOLOGY CENTER

2227 N Belt Highway, St. Joseph, MO 64506
TEL 816.233.0022 FAX 816.233.0023
www.hearquality.com

Patient Information

Patient Name: First ____ Last ____ | Date: ____

Gender: ◯ Male ◯ Female   Marital Status: ◯ Married ◯ Single ◯ Widow   D.O.B. ____ / ____ / ____

Home Phone: ____   SS#: ____ - ____ - ____

Cell Phone: ____   Work Phone: ____   Ext. ____

Occupation: ____ ◯ Prior ◯ Current

Mailing Address: ____   Apt/Suite: ____

City: ____   State: ____   Zip: ____

Email: ____

Emergency Contact: ____   Phone: ____

Relation to Patient: ____

Primary Care Physician: ____   Phone: ____

How did you hear about us?

◯ Mail	◯ Health/Senior Fair	◯ Website	◯ Referred by Friend: ____
◯ Yellow Pages	◯ Sponsored Event	◯ Insurance	◯ Referred by Physician: ____
◯ Newspaper Ad	◯ Television	◯ Employer	◯ Other: ____

Insurance Information

Please give your insurance information to our front office staff so we can make a copy for our records.

Do you have insurance? ◯ Yes ◯ No   Do you have Medicare? ◯ Yes ◯ No

Name of Policy Holder: ____

Policy Number: ____   Group Number: ____

Patient Agreement

◯ I give permission to my hearing healthcare professional to release information-verbal and written, contained in my medical records and other documents-to my insurance company, rehab nurse, case manager, attorney, employer, healthcare providers, assignees and/or beneficiaries and all other relevant persons. Information that does not identify me as the patient may be used for quality purposes.

◯ I acknowledge that I have agreed that regardless of my insurance status, I am ultimately responsible for the balance of my account for professional services rendered or purchase made.

◯ I have read all the information on this sheet, have provided the requested information, certify this information is true and correct to the best of my knowledge, and hereby give my hearing healthcare professional permission to treat my condition.

◯ I hereby authorize the transfer of my records to be released to Dr. Pamela Shattuck Nelson, Au.D. and Quality Hearing & Audiology Center.

Signature: ____________________   Date: ____________

Signature: ____________________   Date: ____________

Signature of parent or guardian if patient is a minor.

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Patient Name: First Last | Age: | Date:

1. What is the primary reason for today's visit:

2. Are you experiencing problems with your hearing? ◯ Yes ◯ No

   Which ear? ◯ Both ◯ Right ◯ Left

3. Has the hearing loss been: ◯ Gradual ◯ Sudden ◯ Fluctuating

4. How long have you noticed problems with your hearing:

   ◯ Recently ◯ 1-3 Years ◯ 4-6 Years ◯ 7-10 Years ◯ More than 10 Years

5. What do you think may have caused this?

6. Have you had your hearing tested before? ◯ Yes ◯ No

   If yes, when:

7. What was the outcome of your previous hearing test?

   ◯ No Loss ◯ Mild Loss ◯ Hearing Aids Recommended ◯ NA

8. Do you currently use a hearing aid? ◯ Yes ◯ No

9. Have you ever used a hearing aid(s)? ◯ Yes ◯ No

10. Do any members of your family have a hearing problem? ◯ Yes ◯ No

11. Do you have a history of ear infections? ◯ Yes ◯ No

12. Have you had any of the following in the last six months? (Select all that apply)

    ◯ Medically Diagnosed Ear Pathology ◯ Ear Pain
    ◯ Pressure or Fullness in the Ears ◯ Ear Drainage

13. Have you had surgery on your ears? ◯ Yes ◯ No

    If yes, which ear? ◯ Both ◯ Right ◯ Left

14. Do you hear noises in your ears or head? (Tinnitus) ◯ Yes ◯ No

    If yes, which ear? ◯ Both ◯ Right ◯ Left

    If yes, how often do you hear these noises?

    ◯ Constantly ◯ Frequently ◯ Occasionally ◯ Very Seldom

15. How would you describe the noise?

    ◯ Ringing ◯ Buzzing ◯ Roaring ◯ Crickets ◯ Pulsating ◯ NA

16. Are you experiencing any problems with dizziness? ◯ Yes ◯ No

    If yes, is your dizziness accompanied by the following?

    ◯ Nausea ◯ Vomiting ◯ Noises in Ears ◯ Loss of Consciousness

Doctor's Notes:

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17. Do you have or have you had any of the following? (Select all that apply)

- ◯ Sinuses/Allergy
- ◯ Meningitis
- ◯ Mumps
- ◯ Measles
- ◯ Thyroid
- ◯ Diabetes
- ◯ Stroke
- ◯ Heart Attack
- ◯ High Blood Pressure
- ◯ Head Injury
- ◯ Arthritis
- ◯ Appetite Change
- AIDS/HIV
- ◯ Cancer
- ◯ Blood Disorder
- ◯ High Cholesterol
- ◯ Chicken Pox
- ◯ Diphtheria
- ◯ Encephalitis
- ◯ Fatigue
- ◯ Genetic Disorders
- ◯ Headaches
- ◯ Heart Problems
- ◯ High Fevers
- ◯ Scarlet Fever
- ◯ Typhoid
- ◯ Tonsillitis
- ◯ Vascular Problems
- ◯ Other: ____________

18. Do you take medications regularly? (Please list on bottom right) ◯ Yes ◯ No

19. Allergies to medication or plastics? ____________

20. Have you ever been exposed to excessively loud noises? ◯ Yes ◯ No

21. Are you currently employed? ◯ Yes ◯ No ◯ Retired

22. What is or was your occupation? ____________

Please fill out the below questions:

23. Eye problems? (e.g., blurred vision or pain) ◯ Yes ◯ No

24. Nose, throat or mouth problems? ◯ Yes ◯ No
(e.g., trouble swallowing, nose bleeds, denture issues, pain)

25. Cardiovascular symptoms? ◯ Yes ◯ No
(e.g., hypertension, chest pain, swelling, palpitations, heart surgery)

26. Respiratory symptoms? ◯ Yes ◯ No
(e.g., shortness of breath, cough, wheezing)

27. Gastrointestinal symptoms? ◯ Yes ◯ No
(e.g., nausea, vomiting, weight changes, diarrhea)

28. Musculoskeletal symptoms? ◯ Yes ◯ No
(e.g., joint pain, swelling, recent trauma)

29. Neurological symptoms? ◯ Yes ◯ No
(e.g. numbness, headaches, seizures, muscles weakness)

30. Psychiatric issues? ◯ Yes ◯ No
(e.g., depression, anxiety, compulsions)

31. Endocrine symptoms? (e.g., frequent urination, hot flashes) ◯ Yes ◯ No

32. Hematologic/lymphatic symptoms? ◯ Yes ◯ No
(e.g., bleeding gums, bruising, swollen glands, clotting issues)

33. Allergic/immunologic symptoms? ◯ Yes ◯ No
(e.g., hives, asthma, itching, immune deficiency)

Doctor's Notes:

Medication List: