



11451 KATY FWY, SUITE 520
HOUSTON, TX 77079
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TODAYS DATE _____

LAST NAME _____ FIRST NAME _____ MI _____

MALE FEMALE MARRIED SINGLE WIDOW(ER)

ADDRESS _____

CITY _____ STATE _____ ZIP _____

CELL PHONE _____ HOME PHONE _____

EMAIL ADDRESS _____

DATE OF BIRTH _____ PAST/PRESENT OCCUPATION _____

ACCOMPANYING PARTY OR COMPANION _____ RELATIONSHIP _____

FAMILY PHYSICIAN NAME _____ CITY _____ PHONE _____

PERMISSION TO RELEASE A COPY OF TEST INFORMATION TO PHYSICIAN YES NO

PATIENT SIGNATURE _____

MEDICAL AND HEARING HEALTH HISTORY

Do you have any of the following? (PLEASE CIRCLE YES OR NO)

ANY DEFORMITY OF THE EAR? YES NO

ANY SUDDEN OR RAPID HEARING LOSS IN THE PAST 90 DAYS? YES NO

ANY PAIN OR DISCOMFORT IN THE EAR? YES NO

ANY ACUTE OR RECURRING DIZZINESS? YES NO

ANY PREVIOUS EAR INFECTIONS? YES NO

ANY ACTIVE DRAINAGE FROM THE EAR? YES NO

In which ear is your hearing worse? RIGHT LEFT BOTH

Have you ever found it necessary to have a doctor remove wax from your ears **BEFORE TODAY?** YES NO

Which ear do you use the telephone? RIGHT LEFT

Do you have any sinus or allergy problems? YES NO If yes please explain _____

Are you a diabetic? YES NO If yes are you Insulin dependent? _____

Have you had exposure to excessive noise? YES NO Explain _____

Do you have a history of firearm use? YES NO

HAVE YOU EXPERIENCED ANY MEMORY LOSS? YES NO

Do you have ringing or other noises in your ear? YES NO If yes which ear? _____

On a scale from 1-10, 10 being the worst, how would you rate your ringing/tinnitus? 1 2 3 4 5 6 7 8 9 10

Have you received any medical or surgical treatment for your hearing loss? YES NO

When? _____

Please Explain

Amplification History

When was your last hearing exam? _____

Have you ever worn hearing aids before? YES NO

Are you a **current** hearing aid wearer? YES NO TYPE _____

Which ear(s) were fitted? BOTH LEFT RIGHT

If yes, and you could improve something about your current hearing aids, what would that be?

Is there any other information you would like your audiologist to know?

How did you hear about us? _____

Where Do You Experience Hearing Challenges?

Thank you for visiting us today. To help us provide you with the best possible care, please take a few moments to complete the following questionnaire. Your responses will help make your hearing evaluation and fitting appointment more efficient, effective and successful.

Instructions

- Please read the following statements.
- Beside each statement, mark the circle that **best** describes your experience in each situation.

Name: _____ Date: _____

	Always	Sometimes	Never
I have to ask people to repeat themselves even when I am in a quiet conversation with one or two people.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
My family members complain that I need to turn the television volume louder than they do.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I talk on the telephone or cell phone, I miss some of what is being said.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
During a card game (or other games) around a table, I have difficulty hearing the conversation.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I am in a busy public place, such as a shopping center, I have difficulty communicating with others.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
In meetings, I have to strain to make sure I hear everything.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I'm eating in a restaurant, I have to ask my dining companion to repeat things.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I miss a lot of information during church and/or classroom lectures.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
When I'm listening to music/concerts, I miss parts of the performance.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
If I'm in the car with others who are talking, I can't hear what they're saying.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Do friends or family members tell you that you have a hearing problem?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



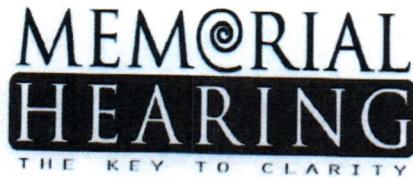
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Cerumen Management Waiver

If needed, I give permission to the providers of Memorial Hearing, INC to remove cerumen (ear wax) from my ear(s), as deemed appropriate with instrumentation, suction, drops, and/or irrigation. I understand that occasionally redness, soreness, fullness and in rare cases, minor bleeding, canal laceration, hearing loss, infection and/or perforation of the tympanic membrane can occur. I give my permission to have this procedure done and understand and agree not to hold the professional or the clinic liable if any of the above-mentioned symptoms occur. I also understand that every effort to remove the wax/debris will be made but that it's not guaranteed that it will be fully removed.

Signature: _____

Date: _____



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Memorial Hearing, INC to use and disclose **protected health information (PHI)** about me to carry out **treatment and health care operations (TPO)**. (The Notice of HIPAA Privacy Practices provided by Memorial Hearing, INC describes such uses and disclosures more completely).

I have been notified of my right to and have been given the opportunity to review the Notice of HIPAA Privacy Practices prior to signing this consent. Memorial Hearing, INC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Memorial Hearing, INC, 11451 Katy Freeway, Suite 520 Houston, TX 77079.

With this consent, Memorial Hearing, INC may call, mail, or email my home or other alternative location and leave a message on voice mail or in person, in reference to any items that assist the practice in carrying out TPO, such as financing and payment, appointment reminders, insurance items and pertaining to my clinical care, including laboratory test results, among others, as long as written items are marked "Personal and Confidential".

I have the right to request that Memorial Hearing, INC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow Memorial Hearing, INC to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Memorial Hearing, INC may decline to provide treatment to me.

Dated this ____ day of _____, 20____.

SIGNED BY:

Patient or Legal Guardian Signature

If Guardian, relationship to Patient

Printed Name of Patient

Printed name of Guardian



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CANCELLATION/ CONFIRMATION / NO SHOW POLICY

Please understand that appointment times are limited. WE REQUIRE CONFIRMATION BY 2 PM the day before your appointment. **If you do not show up to your appointment or do not confirm, cancel, or reschedule your appointment by 2 pm the business day before, you will owe \$50 NO MATTER THE REASON and your appointment will automatically be canceled.** *Monday appointments require cancellation by 2 pm Friday. Thank you!

*If applicable, pre-paid deposit patients will lose the non-refundable deposit if canceled at any time, or if no show / not rescheduled by 2 pm the business day before.

I have received and understand the cancellation / no show policy as stated above.

SIGNATURE

DATE

TH INVENTORY (Newman et al)

Name/ID: _____

Date: _____

INSTRUCTIONS: The purpose of the questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer YES, SOMETIMES OR No, to each question. Please Do Not Skip Any Questions.

F-1	Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
F-2	Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
E-3	Does your tinnitus make you angry?	Yes	Sometimes	No
F-4	Does your tinnitus make you feel confused?	Yes	Sometimes	No
C-5	Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
E-6	Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
F-7	Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
C-8	Do you feel as though you can not escape your tinnitus?	Yes	Sometimes	No
F-9	Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies, etc..)?	Yes	Sometimes	No
E-10	Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
C-11	Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
F-12	Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
F-13	Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
E-14	Because of your tinnitus do you find that you are often irritable?	Yes	Sometimes	No
F-15	Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
E-16	Does your tinnitus make you upset?	Yes	Sometimes	No
E-17	Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
F-18	Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
C-19	Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
F-20	Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
E-21	Because of your tinnitus, do you often feel depressed?	Yes	Sometimes	No
E-22	Does your tinnitus make you feel anxious?	Yes	Sometimes	No
C-23	Do you feel that you can no longer cope with your Tinnitus?	Yes	Sometimes	No
F-24	Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
E-25	Does your tinnitus make you feel insecure?	Yes	Sometimes	No

F _____ C _____ E _____ T _____