Complete Hearing

4200 pioneer woods drive | lincoln ne 68506 | 402/489-4418 | (f) 402/489-2268 | **complete-hearing.com**

Welcome to **Complete Hearing**! We are delighted that you have chosen our practice for your health care needs. We value your time and are looking forward to providing you with an unmatched healthcare experience.

When you arrive at our practice, please be sure to have the following with you:

- **Intake Paperwork**.
  Please complete the front and back of all paperwork. If a question or form does not pertain to you, please write **'N/A' or 'NONE'.**

- **Current insurance card(s)**.
  All eligible procedures will be filed with your insurance. Non-eligible services will occur and range from $25 - $287. These will be disclosed to you and are due at the time of your visit.

  If *Medicare or Medicaid* is your primary insurance, a physician order must be sent from your Primary Care Physician for us to bill your insurance. To obtain an order, please notify them of your appointment and that you need an order for "decreased hearing" or for the symptoms we are evaluating.

  The order/referral can be faxed to us at **402/489.2268**.

- **A friend or family member whose voice is familiar to you**.
  Please have a friend or family member present during the consultation appointment. Having a familiar voice and a "second set of ears" is helpful during the evaluation and review of your test results.

Do not hesitate to call if you have any questions. If you are unable to keep your scheduled appointment, we ask that you notify us at least 24 hours in advance.

We are looking forward to meeting you,

Summer Brown, M.S., H.I.S., Dr. Sandra Miller, Au.D.
Dr. Meghanne Wetta, Au.D., Dr. Macy Schott-Miller, Au.D.,
and Dr. Sam Ducote, Au.D.

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PATIENT INFORMATION

Last name: _____ First name: _____ Middle initial: _____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: ☐female / ☐male

Living facility name: _____

Home address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____ Email address: _____

Phone numbers: Cell _____ Home _____ Work _____

Marital Status: ☐single / ☐married* / ☐divorced / ☐widowed / ☐partner *Spouses name: _____

Primary Care Physician: _____ Referring Physician: _____

Would you like today's findings sent to your referring or PCP? ☐Yes ☐No

What is your preferred language? ☐English ☐Spanish ☐Other: _____

Employment: ☐full-time**/ ☐part-time**/☐retired/☐unemployed Occupation: _____

**Employer's Name: _____ **Employer's Phone#: _____

RESPONSIBLE PARTY

Last name: _____ First name: _____ Middle initial: _____

Preferred first name: _____ Birthdate: _____ Age: _____ Gender: ☐female / ☐male

Home address: _____ Apt #: _____

City: _____ State: _____ Zip code: _____ Email address: _____

Phone numbers: Cell _____ Home _____ Work _____

Marital Status: ☐single / ☐married* / ☐divorced / widowed / ☐partner* Spouses name: _____

Employment: ☐full-time**/☐part-time**/☐retired/☐unemployed Occupation: _____

**Employer's Name: _____ **Employer's Phone#: _____

MEDICATIONS

Do you currently take any medications? ☐Yes ☐No If yes, please complete the following.

MEDICATION (TO INCLUDE: PRESCRIPTIONS/VITAMINS & OVER-THE-COUNTER MEDICATIONS)	DOSAGE AMOUNT	ORAL / INJECTION	HOW MANY TIMES / DAY	REASON FOR TAKING MEDICATION

*IF YOU NEED MORE SPACE, PLEASE CONTINUE ON THE OTHER SIDE.

How did you hear about Us? _____

Yellow pages, Newspaper, Radio, TV, Mail, Online, Other: **Please name** if Doctor / Friend / Family Member

Name of person with you today? _____

Thank you for taking the time to fill out this release. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

Signature: _____ Date: _____

If someone other than the patient filled out this form, please sign & state relationship to patient.

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Patient name: _____ Preferred first name: _____ Birthdate: _____

Please list all allergies: (To include but not be limited to: Food, Medications, Plastics, etc.)_____

_____

Tobacco Use: ☐Past ☐Current ☐Never Use: ☐Cigarettes ☐Cigars ☐Pipe ☐Smokeless ☐Vaping

Do you drink alcoholic beverages? ☐Yes ☐No How often: ☐Daily ☐Weekly ☐Monthly ☐Occasionally ☐Rarely

Do you currently use recreational drugs? ☐Yes ☐No Which drugs & how often:_____

Have you experienced any of the following major medical problems? (Please *list the approximate date* of diagnosis)

☐AIDS/HIV
☐Anxiety
☐Arthritis
☐Blood Disorders/Thinner
☐Cancer _____
☐Chicken Pox
☐Depression
☐Dementia/Alzheimer's
☐Diabetes I or II
☐Encephalitis
☐Fatigue
☐Genetic Disorders _____
☐Headaches/Migraines
☐Head/Neck Injury
☐Heart Problems
☐High Blood Pressure
☐Malaria
☐Measles
☐Meningitis
☐Mumps
☐Scarlet Fever
☐Stroke
☐TMJ
☐Visual difficulties/disturbances

List all significant medical history if it was not mentioned above: _____

_____

Are you **currently** experiencing any of the following symptoms?

☐ Eye problems (such as blurred or double vision, pain)
☐ Nose, throat, or mouth problems (such as trouble swallowing, nose bleeds, dental issues)
☐ Cardiovascular issues (such as hypertension, chest pain, swelling, palpitations)
☐ Respiratory issues (such as shortness of breath, cough, wheezing)
☐ Gastrointestinal issues (such as nausea, vomiting, weight changes, diarrhea, pain)
☐ Musculoskeletal issues (such as joint pain, swelling, recent trauma)
☐ Neurological symptoms (such as numbness, headaches, tingling, seizures, muscle weakness)
☐ Psychiatric issues (such as depression, anxiety, compulsions)
☐ Endocrine symptoms (such as frequent urination, hot flashes)
☐ Hematologic/lymphatic symptoms (such as bleeding gums, bruising, swollen glands)
☐ Allergic/immunologic symptoms (such as hives, asthma, itching, immune deficiency)

Comments related to symptoms mentioned above: _____

_____

Has your hearing been previously tested? ☐Yes ☐No

If yes, please list when and the results, if known: _____

Why have you decided to have your hearing tested today? _____

_____

When did you first notice a problem with your hearing? ☐Sudden Onset ☐Months Ago ☐Years Ago

Do you feel your hearing is better in one ear? ☐Yes ☐No If yes, which ear: ☐Right ☐Left

Regarding your ears/hearing, are you currently experiencing any of the following?

☐Dizziness

☐Unsteady/Balance struggles ☐Lightheadedness ☐True spinning sensations

Is it accompanied by: ☐Nausea ☐Ringing/Noises in ear(s) ☐Hearing loss ☐Visual disturbances ☐Other

Take a Vitamin D supplement: ☐Yes ☐No

Please describe *when* it happens, *how often*, *how long* & can you do anything to *alleviate* the symptoms?

_____

☐Falling Down

How many falls in the past 12 months: _____

Have you been injured: ☐Yes ☐No Describe: _____

Take a Vitamin D supplement: ☐Yes ☐No

☐Cerumen/Ear Wax Buildup ☐Right ☐Left

☐Ear Deformity ☐Right ☐Left

☐Ear Drainage ☐Right ☐Left

☐Ear Pain ☐Right ☐Left

☐Ear Pressure/Fullness ☐Right ☐Left

☐Family History of Hearing Loss

Who is the family member(s) & approximate age of known hearing loss: _____

_____

☐History of Ear Infections ☐Right ☐Left

☐History of Noise Exposure

Please list the types of noise: _____

Did you wear hearing protection when exposed to these noises? ☐Yes ☐No

☐Itchy Ears ☐Right ☐Left

☐Previous Ear Surgery ☐Right ☐Left

What for & when:_____

☐Tinnitus/Ringing/Buzzing in the Ears ☐Right ☐Left

How long have you experienced it or When did it start? _____

Is it constant or does it come/go? _____

Do you notice it more during the day or night? _____

Please describe the sound: Pitch (high/low) / Roaring / Thumping / Crickets / Cicadas ?_____

_____

Are there conditions/times you notice the sounds are worse? _____

How do the sounds affect your sleep mood / concentration abilities / anxiety? _____

_____

If there are other medical experiences or symptoms regarding your ears that is not mentioned above? Please provide this information here: _____

_____

Thank you for taking the time to fill out this form. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

If someone other than the patient filled out this form, please sign below & state relationship to patient.

Signature:_____ Date:_____

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Instructions: Listed below are statements regarding different listening environments. For each statement, please check the appropriate response: Yes / No / Sometimes (ST). If you currently wear hearing devices, please answer each question according to your experience with your hearing devices on.

1. When I am having a one-on-one conversation in quiet, I have difficulty understanding..... ☐Yes ☐No ☐ST
2. I have to ask unfamiliar people to repeat themselves..... ☐Yes ☐No ☐ST
3. I have difficulty understanding conversation when several people are talking..... ☐Yes ☐No ☐ST
4. When I'm at a restaurant or in the dining hall, understanding speech is difficult..... ☐Yes ☐No ☐ST
5. At times, I miss information when I'm listening to a lecture or sermon..... ☐Yes ☐No ☐ST
6. At times, I miss information when in a large group or meeting..... ☐Yes ☐No ☐ST
7. I have trouble understanding others when in the car..... ☐Yes ☐No ☐ST
8. I have difficulty when listening to TV or radio..... ☐Yes ☐No ☐ST
9. I have difficulty hearing on the phone..... ☐Yes ☐No ☐ST
   Which ear do you use the telephone on? ☐Right ☐Left
   Do you use a cell phone? ☐Yes ☐No Which brand: _____
10. I wish people would talk louder..... ☐Yes ☐No ☐ST
11. I wish people would talk clearer..... ☐Yes ☐No ☐ST
12. I have difficulty hearing women or children's voices..... ☐Yes ☐No ☐ST
13. I have difficulty hearing men's voices..... ☐Yes ☐No ☐ST
14. Hearing difficulties cause me to have disagreements with my family or friends..... ☐Yes ☐No ☐ST
15. My hearing difficulties restrict my personal or social life..... ☐Yes ☐No ☐ST

Please list the top three situations where you would most like to hear better:

1) _____

2) _____

3) _____

Instructions: What is your most important consideration regarding hearing devices? Rank in order the following factors with 1 as the most important and 5 as the least important. Place an X on the line if the item has no importance to you.

_____ Inconspicuous Appearance

_____ Understanding Speech Better

_____ Benefit in Noise Environments

_____ Cost

_____ Service

Instructions: Do you prefer hearing devices that: (Please check one.)

_____ Are completely automatic, therefore, you do not have to make any adjustments to them.

_____ Allow you to adjust the volume and change the listening programs as you see fit.

_____ No Preferences.

Amplification History:

Do you currently or have you worn hearing devices? ☐NO ☐YES If yes, which ear: ☐Right ☐Left ☐Both

If no, please skip the remainder of the questionnaire and sign at the bottom of this page.

How long have you been wearing hearing devices? ☐Less than 1 year ☐1-10 years ☐More than 10 years

What year did you buy your current hearing devices? _____

If known, please list the manufacturer, model and/or style of hearing device that you currently wear:

_____

Approximately how many hours a day do your wear your hearing devices? _____

How satisfied are you with your hearing devices? (Check one)

☐Very Satisfied ☐Satisfied ☐Neutral ☐Dissatisfied ☐Very Dissatisfied

Please explain: _____

_____

_____

Thank you for taking the time to fill out this questionnaire. Your responses will assist us in providing you with the best hearing health care. Please sign below indicating that the information in this form has been read, understood, filled out completely & accurately to the best of your knowledge.

Printed name: _____ DOB: _____

Signature: _____ Date: _____

Tinnitus Handicap Inventory (THI)

Name: _____ Date: _____

Instructions: The purpose of this questionnaire is to identify, quantify, and evaluate the difficulties that you may be experiencing because of tinnitus. Please do not skip any questions. When you have answered all the questions, add up your total score, based on the values for each response.

If applicable, complete for current symptoms.

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

Complete Hearing

Balance Questionnaire

If applicable, complete for past or current symptoms.

PATIENT NAME:_____ DATE:_____

Balance disorders may appear with a variety of symptoms. Some individuals may experience *true spinning*, while others may have *imbalance or unsteadiness*. Please spend a few minutes answering the questions regarding your history and symptoms.

BEFORE MY SYPMTOMS STARTED I HAD:

_____ Changes in Medication/Health
_____ Head Trauma/Concussion
_____ Fallen/Whiplash
_____ Upper Respiratory Infection/Flu
_____ Increased Stress Levels
_____Been on a boat/airplane/long car ride
_____ Headaches
_____ Virus (Shingles/Cold Sores)
_____ Exposed to irritating fumes/toxins

ONSET

When did it **first** occur? _____

How many episodes have you had? _____

Is it constant or intermittent? _____

If intermittent, are you symptom free between episodes? ____ Yes ____No
Do you take any medications for dizziness? ____ Yes ____No
If Yes: Medication & When Used?_____
Do you take medications for migraines? ____Yes ____No
If Yes: Medication & When Used?_____

CURRENT SYMPTOMS

Date and details of your **most recent** episode? _____

_____

Please *mark all that apply;*

When Dizzy I Feel:

_____ I am spinning
_____ Room is spinning
_____ Lightheaded
_____ Unsteady
_____ Loss of Balance/Fall
_____ Other

My Symptoms Last:

_____ Seconds
_____ Minutes
_____ Hours
_____ Days
_____ Weeks
_____ Months

My Symptoms Are:

____ Mild
____ Moderate
____ Severe
____ Debilitating

MY SYMPTOMS ARE MOST NOTICALBE WHEN:

_____ Lying Down
_____ Rolling over
_____ Getting out of bed
_____ Tilting my head back
_____ Moving head side to side
_____ Walking
_____ Driving
_____ Fatigued
_____ Stressed

WHEN "DIZZY" I ALSO EXPERIENCE:

_____ Ringing in the ears
_____ Hearing Loss/Ear Fullness
_____ Nausea/Vomitting
_____ Blurred/Double Vision
_____ Head Fullness
_____ Shimmers in Vision
_____ Light/Sound/Smell Sensitivity
_____ Slurred Speech
_____ Headache (B4/During/After)

GENERAL MEDICAL HISTORY

_____ Anxiety
_____ Depression
_____ Obsessive Compulsive Disorder
_____ Epilepsy
_____ Seizures
_____ Cold Sores/Fever Blisters
_____ Hearing Loss
_____ Tinnitus
_____ Memory Problems
_____ Confusion
_____ Osteoporosis
_____ Neuropathy
_____ Clumsiness/Weakness of Arms/Legs
_____ Motion Sickness
_____ High Blood Pressure
_____ Diabetes
_____ Headaches
_____ Double or Blurred Vision
_____ ENT or Neurology Consultation
Dates:_____

_____ Imaging Studies MRI? CT Scan?
Dates:_____

HEADACHES

_____ Have had 3 – 4 memorable headaches
_____ Family History of Migraines
_____ Throbbing/Pulsating Headaches
_____ Visual Disturbances (Auras/Sparkles)
_____ Aggravated by physical activity
_____ Located on one side of your head
_____ Had nausea/vomiting w/headache
_____ Relived by being in quiet/darkness

HEALTH & WELLNESS

How many hours do you sleep at night? _____
Caffeine? How much daily? _____
How often do you eat out? _____
Do you eat processed foods?
(Foods from a can or box) Yes/No
Do you exercise on a regular basis? Yes/No
Are you under a lot of stress? Yes/No

Females Only

Menopausal Status: Pre/Peri/Post

Hysterectomy: Full/Partial
When?_____

Hormone Panel: Normal/Abnormal
When?_____

Dizziness Handicap Inventory (DHI)

Complete Hearing

PATIENT NAME:_____

DATE:_____

Please mark an "x" in the appropriate box regarding your dizziness/imbalance symptoms

If applicable, complete for current symptoms.

		YES	SOMETIMES	NO
P1	Does looking up increase your problem?	☐	☐	☐
E2	Because of your problem, do you feel frustrated?	☐	☐	☐
F3	Because of your problem, do you restrict your travel for business or recreation?	☐	☐	☐
P4	Does walking down the aisle of a supermarket increase your problems?	☐	☐	☐
F5	Because of your problem, do you have difficulty getting into or out of bed?	☐	☐	☐
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to the movies, dancing, or going to parties?	☐	☐	☐
F7	Because of your problem, do you have difficulty reading?	☐	☐	☐
P8	Does performing more ambitious activities such as sports, dancing, household chores (sweeping or putting dishes away) increase your problems?	☐	☐	☐
E9	Because of your problem, are you afraid to leave your home without having without having someone accompany you?	☐	☐	☐
E10	Because of your problem have you been embarrassed in front of others?	☐	☐	☐
P11	Do quick movements of your head increase your problem?	☐	☐	☐
F12	Because of your problem, do you avoid heights?	☐	☐	☐
P13	Does turning over in bed increase your problem?	☐	☐	☐
F14	Because of your problem, is it difficult for you to do strenuous homework or yard work?	☐	☐	☐
E15	Because of your problem, are you afraid people may think you are intoxicated?	☐	☐	☐
F16	Because of your problem, is it difficult for you to go for a walk by yourself?	☐	☐	☐
P17	Does walking down a sidewalk increase your problem?	☐	☐	☐
E18	Because of your problem, is it difficult for you to concentrate?	☐	☐	☐
F19	Because of your problem, is it difficult for you to walk around your house in the dark?	☐	☐	☐
E20	Because of your problem, are you afraid to stay home alone?	☐	☐	☐
E21	Because of your problem, do you feel handicapped?	☐	☐	☐
E22	Has the problem placed stress on your relationships with members of your family or friends?	☐	☐	☐
E23	Because of your problem, are you depressed?	☐	☐	☐
F24	Does your problem interfere with your job or household responsibilities?	☐	☐	☐
P25	Does bending over increase your problem?	☐	☐	☐

Used with permission from GP Jacobson. Jacobson GP, Newman CW: The development of the Dizziness Handicap Inventory. Arch Otolaryngol. Head Neck Surg 1990;116: 424-427

For Office Use Only
Score P: _____ E: _____ F: _____

16-34 Points (mild)
36-52 Points (moderate)
54+ Points (severe)

Center of Specialty Care
The American Institute of Balance®

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