Harbor Audiology & Hearing Services, Inc.
Phone: (253) 851-3932 | Fax: (253) 851- 4216
Hours: Monday-Thursday 9 AM – 5 PM
Friday 9 AM – 4 PM
www.harboraudiology.com

PATIENT (ADULT - VNG) APPOINTMENT INFORMATION

PRIOR TO YOUR APPOINTMENT, PLEASE MAKE CERTAIN TO:

1. Complete the enclosed forms
2. Bring the completed forms with you to the appointment (alternatively you may also fax or email them ahead of time)
3. Bring your insurance card and a valid I.D. to the appointment.
4. Plan ahead and arrive ***at least*** 15 minutes early.
5. If you are scheduled for balance (dizziness) testing, please review the pre-test instructions at least 24 hours prior to your appointment.

Note: Testing procedures take time and we have appointments scheduled throughout the day. For this reason, if you arrive late, you may be forced to wait or we may have to reschedule your appointment at our discretion.

If you have any questions or require further directions, please contact us at (253) 851- 3932.

Thank You!

Harbor Audiology & Hearing Services, Inc.
Phone: (253) 851-3932 | Fax: (253) 851- 4216
Hours: Monday-Thursday 9 AM – 5 PM
Friday 9 AM – 4 PM
www.harboraudiology.com

PRE-APPOINTMENT INFORMATION & INSTRUCTIONS

MEDICATIONS:

Medications can affect your balance/dizziness evaluation by influencing the body's natural responses and thus giving a false or misleading result. As such, you will be instructed to refrain from taking certain medications 24 hours prior to your test time. If you have any questions or concerns about discontinuing your medications, please consult with your doctor.

Please do not take any of the following 24 hours prior to your appointment.

1. **Analgesics-Narcotics**: Codeine, Demerol, Phenaphen, Percocet, Darvocet
2. **Anti-histamines**: Chlor-trimeton, Dimetapp, Disophrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin or any other over-the-counter cough or cold remedies.
3. **Anti-seizure medicine**: Dilantin, Tegretol, Phenobarbital
4. **Anti-vertigo medicine**: Antivert, Ru-vert, Bonine, Meclizine
5. **Anti-nausea medicine**: Atarax, Dramamine, Compazine, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal
6. **Sedatives**: Halcion, Terstoril, Nembutal, Seconal, Dalmane or any other sleeping pill
7. **Tranquilizers**: Valium (diazepam), Librium, Atarax, Vistaril, Serax, Ativan (lorazepam), Librax, Tranxene, Klonopin, Xanax (alprazolam)

You may continue to take all blood pressure medications, diabetic medications, heart medications, thyroid medications, Tylenol, estrogen, etc. Please consult with your physician before discontinuing any prescribed medication.

FOOD AND DRINK:

Please refrain from smoking, eating or drinking large amounts 4 hours prior to testing. You may drink a small amount of water or eat a light snack. **Please avoid caffeine in beverages such as coffee or soft drinks.**

Beer, wine, and liquor will affect your test results. **Please do not consume any alcoholic beverages for 12 hours prior to your appointment.**

OTHER INFORMATION:

Please do not wear any makeup (especially eye makeup) and remove contact lenses before your appointment.

Dress comfortably (slacks are preferred, as you may be required to lie on an exam table).

Balance testing, while typically well tolerated, can sometimes leave you with a temporary feeling of dizziness or unsteadiness. If you have concerns you may want to consider having someone accompany you to/from your appointment.

On the day of your appointment, a single test or battery of tests will be performed. Prior to each test, a brief explanation will be given so that you will have a better understanding of what is being evaluated and why. We make every attempt for your visit to be comfortable and educational. Once your evaluation is complete, each exam will be carefully reviewed. The interpretation process is just as important as your testing so please understand that results may not be discussed in full detail on that day. Once the interpretation has been made, you and/or your doctor will receive a detailed report of your evaluation within one week.

Harbor Audiology & Hearing Services, Inc.
Phone: (253) 851- 3932 | Fax: (253) 851- 4216
Hours: Monday-Thursday 9 AM – 5 PM
Friday 9 AM – 4 PM
www.harboraudiology.com

PATIENT INFORMATION

DUE TO HIPAA REGULATIONS, ALL INFORMATION MUST BE FILLED OUT, OTHERWISE WE WILL NOT BE ABLE TO PROCESS YOUR CLAIM AND YOU MAY BE BILLED FOR MEDICAL SERVICES.

LAST NAME:	FIRST NAME:	
ADDRESS:		
CITY:	STATE:	ZIP CODE:
DATE OF BIRTH:	SOCIAL SECURITY NUMBER: - -	
MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widow/er	GENDER: ☐ M ☐ F ☐ Other	
HOME PHONE:	CELL PHONE:	
MAY WE LEAVE MESSAGES FOR YOU AT THESE NUMBERS? ☐ YES ☐ NO		

MISC CONTACT INFORMATION

EMERGENCY CONTACT:	RELATIONSHIP:
HOME PHONE:	CELL PHONE:
I AUTHORIZE THIS OFFICE TO DISCUSS CARE INFORMATION OR TREATMENT WITH:	
REFERRING PHYSICIAN:	PHONE NUMBER:
HOW DID YOU HEAR ABOUT US? ☐ Friend ☐ Doctor's Office ☐ Internet ☐ Other:	

EMPLOYMENT

EMPLOYMENT STATUS: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Retired ☐ Student	
OCCUPATION:	MAY WE CONTACT YOU AT WORK? ☐ YES ☐ NO
EMPLOYER:	WORK PHONE:
WORK ADDRESS:	

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER:	
POLICYHOLDER NAME:	RELATIONSHIP TO PATIENT:
INSURANCE ID:	GROUP NUMBER:
SECONDARY INSURANCE CARRIER:	
POLICYHOLDER NAME:	RELATIONSHIP TO PATIENT:
INSURANCE ID:	GROUP NUMBER:

Assignment of Benefits

By signing below, you: (1) allow us to submit a claim along with your medical information to your managed care plan, insurance company, or other Program you have identified as potentially providing coverage for hearing aids and service you receive (any of which will be referred to as the "Plan"); (2) allow us to assign your benefits under the Plan for payment directly to us; (3) acknowledge that you understand and agree to pay us for any applicable co-payments, deductibles, and co-insurance under your Plan; and, (4) if the plan allows, acknowledge that you understand and agree to pay for the difference between the price of the hearing aid(s) and/or services and the amount of the benefit collected from your Plan.

SIGNATURE:	DATE:

Harbor Audiology & Hearing Services, Inc.
Phone: (253) 851-3932 | Fax: (253) 851- 4216
Hours: Monday-Thursday 9 AM – 5 PM
Friday 9 AM – 4 PM
www.harboraudiology.com

BALANCE / DIZZINESS QUESTIONNAIRE

NAME: DATE OF BIRTH: TODAY'S DATE:

REFERRING PHYSICIAN: Height: Weight:

Prior patient? ☐ YES ☐ NO

What is your chief complaint (symptoms)?

When and how did this first occur?

How long did it last or is it ongoing?

Have you had this problem before?

When did you last experience your symptoms?

Have your symptoms? ☐ Improved ☐ Worsened ☐ Stayed the same

Have you had any previous testing or therapy for dizziness / imbalance? ☐ YES ☐ NO

If yes, when and where was the testing done?

How would you grade the overall severity of your symptoms on your daily function, using a 1-10 scale with 1 being "no limitations" and 10 representing "incapacitated?" (please circle) 1 2 3 4 5 6 7 8 9 10

Have you ever experienced any of the following? (Please check all that apply)

☐ Double vision	☐ Blindness/loss of vision	☐ Unable to speak/swallow	☐ Slurred speech
☐ Flashes of light	☐ Loss of consciousness	☐ Weakness or numbness on one side (arms, legs, face)	

MEDICAL HISTORY (Please check all that apply)

☐ Abnormal Heart Rhythm	☐ Cytomegalovirus (CMV)	☐ High Fever	☐ Pacemaker
☐ ADD / ADHD	☐ Depression	☐ High / Low Blood Pressure	☐ Parkinson's Disease
☐ Allergy / Sinus Problem	☐ Diabetes	☐ HIV / AIDS	☐ Polio
☐ Alzheimer's / Dementia	☐ Genetic Disorder	☐ Kidney Disease	☐ Rubella
☐ Anemia / Blood Disease	☐ Glaucoma, Cataract	☐ Liver Disease	☐ Scarlet Fever
☐ Anxiety or Depression	☐ Head or Neck Injury	☐ Measles or Mumps	☐ Seizure Disorder
☐ Arthritis	☐ Headaches/Migraine	☐ Ménière's Disease	☐ Stroke
☐ Autoimmune Disease	☐ Heart Disease	☐ Meningitis	☐ Syphilis
☐ Cancer	☐ Hepatitis (A, B, or C)	☐ Multiple Sclerosis	☐ Thyroid Disorder
☐ Cerebral Palsy	☐ Herpes	☐ Neuropathy	☐ TMJ
☐ Chronic Pain	☐ High Cholesterol	☐ Otosclerosis	☐ Tuberculosis
☐ Cleft Palate or Lip			

Other:

DIZZINESS / VERTIGO

Do you have dizziness? ☐ YES ☐ NO (If no, you may proceed to the next section)

If you have dizziness, which best describes it? (check all that apply)

☐ Spinning rotation	☐ Lightheaded	☐ Rocking motion	☐ Head swimming	☐ Floating feeling
☐ Sense of falling	☐ Poor balance	☐ Motion sickness	☐ Tilting/Leaning	☐ Other:

Is your dizziness?

☐ Continuous ☐ Continuous but periodically worsens ☐ Intermittent or episodic

If episodic, how often?	Do you have any warning that the attack is about to start?

If you have attacks of dizziness or periods of worsening, when do they occur? (check all that apply)

☐ When standing up	☐ During weather changes	☐ Turning eyes side to side	☐ With head movement
☐ In crowded places	☐ Seeing things in motion	☐ When straining or lifting	☐ When exercising
☐ When hungry	☐ When stressed	☐ When fatigued	☐ With menstruation
☐ When turning in bed, rolling over or looking up/down		☐ Other:	

EQUILIBRIUM / BALANCE

Do you have loss of balance or unsteadiness? ☐ YES ☐ NO (If no, you may proceed to the next section)

If you have loss of balance or unsteadiness, which best describes your problem? (check all that apply)

☐ Off balance only when standing up	☐ Off balance when walking	☐ Off balance when turning
☐ Off balance when sitting or laying	☐ Off balance in darkness	☐ Off balance on uneven surfaces
☐ Environment seems in motion	☐ Tendency to veer to the side when walking	
☐ Tendency to fall forward/backward	☐ Other:	

Do you get motion sickness easily (airsick, carsick, or seasick)? ☐ YES ☐ NO

Have you had recent falls? ☐ YES ☐ NO **How many times in the last month?**

What caused the fall(s)? **Are you afraid of falling?** ☐ YES ☐ NO

OTOLOGIC HISTORY

Do you have difficulty hearing? ☐ YES ☐ NO	If yes, for how long?
Which ear? ☐ Left ☐ Right ☐ Both	Is the hearing loss? ☐ Sudden ☐ Gradual ☐ Fluctuates
Does this change with your symptoms? ☐ YES ☐ NO	Do you wear hearing aids? ☐ YES ☐ NO
Do you have tinnitus (noise in your ears)? ☐ YES ☐ NO	If yes, for how long?
Which ear? ☐ Left ☐ Right ☐ Both	Is the tinnitus? ☐ Consent ☐ Intermittent ☐ Pulsing
Does the tinnitus change with your symptoms? ☐ YES ☐ NO	

Have you ever experienced any of the following? (Please check all that apply)

Sudden hearing loss ☐ YES ☐ NO	Which ear? ☐ Left ☐ Right When?
Ear pain or fullness ☐ YES ☐ NO	Which ear? ☐ Left ☐ Right Details:
Frequent ear infections ☐ YES ☐ NO	When was the last?
Discharge / drainage ☐ YES ☐ NO	Please describe:
History of ear surgery ☐ YES ☐ NO	Please describe:
History of noise exposure ☐ YES ☐ NO	Please describe:
Family history of hearing loss ☐ YES ☐ NO	Please describe:

SURGICAL HISTORY (please list any surgeries and/or operations that you have had)

MEDICATIONS (please list current medications and what you are taking them for)

(PLEASE LEAVE THIS SECTION AND THE REST OF THIS FORM BLANK)

NOTES:

FDA Reference Criteria	Reference Criteria
1. Visible congenital or traumatic deformity of the ear	1. Otalgia
2. History of active drainage from the ear in previous 90 days	2. Inflammation of the ear
3. History of sudden hearing loss or progressive hearing loss within 90 days	3. Foul smelling or purulent aural drainage
4. Acute or chronic dizziness	4. Otitis media
5. Unilateral hearing loss of sudden or recent onset within 90 days	5. Vertigo-Initial evaluation/recent onset
6. Conductive hearing loss: Audiometric A-B gaps > 15dB at 500-2000Hz	6. Tinnitus-Initial evaluation/recent onset
7. Visible evidence of impacted cerumen or foreign body in canal	7. Blocked feeling in ear
8. Otalgia or ear discomfort	8. Balance disturbance
	9. Spontaneous nystagmus
	10. Symptoms associated with ototoxic drugs
	11. Impacted cerumen
	12. Neurological evaluation
	13. Meniere's disease
	14. Asymmetrical hearing loss-Initial evaluation/recent onset
	15. Sudden hearing loss initial evaluation/recent onset
	16. Perforated tympanic membrane

Audiologist Initials: _____