Where Do You Experience Hearing Challenges?

Intake Questionnaire

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
1. I have to ask people to repeat themselves even when I am in a quiet conversation with one or two other people.	◯	◯	◯
2. My family members complain that I need to turn the television volume louder than they do.	◯	◯	◯
3. When I talk on the telephone or cell phone, I miss some of what is being said.	◯	◯	◯
4. During a card game (or other game) around a table, I have difficulty hearing the conversation.	◯	◯	◯
5. When I am in a busy public place, such as a shopping center, I have difficulty communicating with others.	◯	◯	◯
6. In meetings, I have to strain to make sure I hear everything.	◯	◯	◯
7. When I'm eating in a restaurant, I have to ask my dining companion to repeat things.	◯	◯	◯
8. I miss a lot of information during church and/or classroom lectures.	◯	◯	◯
9. When I'm listening to music/concerts, I miss parts of the performance.	◯	◯	◯
10. If I'm in the car with others who are talking, I can't hear what they're saying.	◯	◯	◯

Circle the top 3 listening situations/environments in which you experience the most difficulty hearing and would like to experience an improvement. (If not outlined above, list below).

_____

_____

Thank you.

Texas Center for Hearing

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* _____

TexasVoiceCenter
Voice, Swallowing, and General ENT

Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Weight:** _____ **Height:** ____'____"

What is your reason for visit? _____

Date symptoms began? _____

Severity of symptoms: ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Incapacitating**

Aggravated by: _____

Relieved By: _____

How many times have you been treated for the problem? _____

List full names & locations of physicians who have treated you for this condition: _____

Have you taken any aspirin or ibuprofen products (Advil, Aleve, etc.) during the past month? Y / N

If yes, what did you take? _____ **When?** _____ **For how long?** _____

Are you taking it now? Y / N

Symptoms Check (✓) symptoms you currently have or have had in the past year.

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Weakness

Respiratory
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Wheezing
- ☐ Cough

Cardiovascular
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Heart problems

Metabolic/Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn or acid reflux
- ☐ Vomiting
- ☐ Nausea

Genitourinary
- ☐ Change in urine color
- ☐ Kidney problems
- ☐ Painful urination
- ☐ Frequent urination

Neurological
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Excessive daytime sleepiness
- ☐ Non-restorative sleep
- ☐ Numbness in legs or arms
- ☐ Blackouts or fainting
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness
- ☐ Headaches
- ☐ Seizures
- ☐ Confusion or memory loss

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Nervousness or increased stress

Dermatologic
- ☐ Skin rash

Musculoskeletal
- ☐ Back pain
- ☐ Bone/joint symptoms
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Rheumatologic symptoms

Immunological
- ☐ Hay fever
- ☐ Hives
- ☐ Chemical sensitivity
- ☐ Environmental allergies
- ☐ Food allergies/sensitivity

Patient Name:_____ DOB: _____

HEENT

Head/Eyes

- ☐ Headache
- ☐ Burning eyes
- ☐ Double vision
- ☐ Discharge from eyes
- ☐ Dry eyes
- ☐ Feeling of something in the eye(s)
- ☐ Sensitivity/pain of eyes to light
- ☐ Redness of the eye(s)
- ☐ Itchy eye(s)
- ☐ Nystagmus
- ☐ Eye pain
- ☐ Scotoma
- ☐ Eye Floaters
- ☐ Tearing
- ☐ Loss of vision

Ears

- ☐ Ear discharge
- ☐ Excessive ear wax
- ☐ Fullness in ears
- ☐ Hearing loss
- ☐ Frequent ear infections
- ☐ Ear pain
- ☐ Tinnitus or ringing in the ears
- ☐ Vertigo
- ☐ Excessive noise exposure

Nose/Sinus

- ☐ Reduced sensation of smell
- ☐ Nasal drainage
- ☐ Nose bleed
- ☐ Facial pain
- ☐ Nasal congestion
- ☐ Nasal obstruction
- ☐ Runny nose
- ☐ Sinusitis
- ☐ Sneezing

Mouth/Throat

- ☐ Change in taste
- ☐ Voice change
- ☐ Cold sores
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Lump in throat
- ☐ Mouth sores
- ☐ Pain when swallowing
- ☐ Post nasal drip
- ☐ Tongue soreness
- ☐ Sore throat/pharyngitis
- ☐ Snoring
- ☐ Tooth pain

Neck

- ☐ Lumps in neck
- ☐ Swollen glands in neck
- ☐ Pain in neck

Other:

_____
_____
_____
_____
_____

Conditions

Check (✓) conditions you currently have or have had in the past year.

Past medical History

- ☐ Environmental Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostaic Hypertrophy
- ☐ Blood Clots
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gall Bladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ Hyperlipidemia
- ☐ Hypertensions
- ☐ Irritable Bowel Diseases
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure
- ☐ Thyroid Disease

Other: _____
_____
_____

Past Surgical Histories *(with approximate dates)*

Other: _____
_____
_____

Family History

Who:	What Condition:	Age of Onset:	Cause of death?

Patient Name:_____ DOB: _____

Social History

Tobacco Use: ☐Yes ☐No ☐Former
Type: _____
Packs/amount per day: _____
Years Smoked: _____
Year Quit: _____

Drinks Alcohol: ☐Yes ☐No ☐Formerly Year Quit: _____
Type: _____ Frequency: _____
Amount: _____ Last Drink:_____

Caffeine Use:
Type: _____
Amount daily: _____

How much water do you drink in a day?

_____

Do you consider yourself a Performing or Visual Artist? ☐Yes ☐No

Occupation:
Employer: _____ Occupation: _____
Employment status: _____ Restrictions: _____

Medications

List all prescription and over-the-counter medications and their dosages you are currently taking- **please ensure that spelling is correct**

_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies, Severity & Reaction

_____ _____
_____ _____
_____ _____

Preferred Pharmacy: _____ Phone: _____

To the best of my knowledge the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health.

_____ _____
Signature of patient, parent, guardian, or personal representative Date

_____ _____
Please print name of patient, parent, guardian, or personal representative Date

_____ _____
Reviewed by Date

TexasVoiceCenter
Voice, Swallowing, and General ENT

6550 Fannin, Suite 2025
Houston, TX 77030
(713) 796-2181

PATIENT INFORMATION—PLEASE PRINT

Last Name:	**First Name:**	**Middle Initial:**	
Circle: Mr Mrs Miss MD PhD DDS	**Marital Status:**	**Spouse's Name:**	
☐ **Male** ☐ **Female** **Race:**	**Birth Date:**	**Age:**	**Hispanic/Latino:** ☐ **Yes** ☐ **No**
Home Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Cell Phone:**	
Email Address:			
Social Security #:	**Driver License #:**	**State:**	
Occupation:	**Other Family Members Seen by TVC:**		
Pharmacy Name & Address	**Pharmacy Phone:**		**Pharmacy Fax:**
Employer & Address:	**City:**	**State:**	**Zip:**
If Student, School Attending:	☐ **Full Time** ☐ **Part Time:**		
Full Name of Referring Physician:	**Address:** **City:**	**State:**	**Zip:**
Other Physicians Caring for You:	**Specialty:**	**Phone:**	
In Case of Emergency, Notify:	**Relationship to you:**	**Home #:**	**Other #:**
Please list family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:			

FINANCIALLY RESPONSIBLE PARTY (if other than patient)

Last Name:	**First Name:**	**Middle Initial:**	
Home Address:	**City:**	**State:**	**Zip:**
Home Phone:	**Work Phone:**	**Relationship to patient:**	
Social Security #:	**Driver License #:**	**Birth Date:**	**Age:**
Employer & Address:	**City:**	**State:**	**Zip:**

INSURANCE COVERAGE

PRIMARY Insurance Co.:	**Member ID #:**	
Insured's Name:	**Relationship to Patient:**	
Insured's ID #:	**Insured's Soc Security #:**	**Date of Birth:**
SECONDARY Insurance Co.:	**Member ID #:**	
Insured's Name:	**Relationship to Patient:**	
Insured's ID #:	**Insured's Soc Security #:**	**Date of Birth:**

AUTHORIZATION

I hereby authorize the Texas Voice Center to furnish information associated with this illness/accident to my referring physician, other allied health professionals, or my insurance carrier.

Patient/Guarantor Signature: _____ **Date:** _____

TexasVoiceCenter
Voice, Swallowing, and General ENT

CONSENT FOR TREATMENT

All procedures will be explained to you.
Specialized procedures may require an additional consent form.

"I hereby consent to a general and specialized examination of my head, neck and organ systems relating to my condition. I understand that the examination and treatment *may* include any of the following:

- General medical history
- Inspection of my head, ears, eyes, nose, mouth, throat and neck
- Examination with mirrors or lighted scopes (endoscopy)
- Examination of the chest, abdomen and nervous system, when appropriate
- Examination and cleaning of my ears under a microscope
- The use of topical or local anesthesia
- The use of ear impression materials for ear related products, equipment or services
- The application or injection of antibiotics or other therapeutic drugs
- The collection of secretions, sputum or drainage
- Venipucture for blood collection
- X-rays, hearing and balance studies, or audiologic testing when indicated
- Photographic or video documentation of my findings

"I understand that my medical information, including photographs or videotapes, will be handled confidentially and that my identity will remain anonymous in any presentation of case materials."

"I have the right to ask questions regarding the purposes and risks of the examination, diagnostic studies and treatments."

"I understand that this consent remains in effect for all subsequent clinic visits to Texas Voice Center (TVC), and applies to all physicians in the group as well as medical staff assisting the physicians."

"I am over 18 years of age, and therefore have the legal right to consent to this treatment."

Patient's Signature _____ Date_____

If patient is a Minor (under age 18, unmarried, not financially independent, not in the armed forces on active duty), parent or legal guardian MUST SIGN BEFORE patient is examined.

Patient's Name _____ Date _____

Signature of parent or legal guardian _____ Date _____

TexasVoiceCenter
Voice, Swallowing, and General ENT

FINANCIAL POLICY

Thank you for selecting Texas Voice Center (TVC) for your medical care. In order to prevent any misunderstanding over the responsibility of payment for medical and surgical services provided to our patients, we supply you with the following information:

The patient, guarantor, or the person bringing the patient (if the patient is a minor), is responsible for payment of any balance due following the office visit, test or procedure. We accept cash, personal checks (NSF charge: $25), and credit cards (American Express, Discover, VISA, MasterCard). In the case of divorced parents, the parent bringing the child to the office is responsible for payment of any balance due at the time of service. Should you need documentation to secure reimbursement, a copy of the bill is furnished at each visit.

If a referral from your primary care physician is required by your insurance plan, it must be received in our office by your appointment time. If we have not received the referral by the time of your arrival, your appointment will be rescheduled. You will be asked for your insurance card and driver's license at the registration desk for identification purposes.

TVC Contracted Insurance Coverage (In-Network benefits)
If you have coverage through an insurance company that has a contract with the doctor you are seeing, we require a copy of your insurance card and payment of your deductible and/or co-insurance at the time of service.

Non-TVC Contracted Insurance Coverage (Out-of-Network benefits)
If you have coverage through an insurance company that does not have a contract with the doctor you are seeing, we require a copy of your insurance card, and payment of your out-of-network deductible and/or co-insurance at the time of service. We will file the claim as a service to you.

Medicare
Office visits to a doctor are covered under Part B of the Medicare program. Medicare pays 80% of their allowable charges after you pay the annual deductible for the calendar year, and you are responsible for any non-covered services. If you have supplemental insurance, we will be glad to file it for you.

I have read all the information above and agree that, regardless of my insurance status, I am responsible for my account balance for any professional services rendered. Disclosed, non-covered medical services are my responsibility.

In the event my insurance company is billed, I irrevocably assign and transfer benefits to Texas Voice Center. A photocopy of this agreement shall be considered as effective and valid as the original.

Signature of responsible party _____ Date _____

I authorize the release of any medical information necessary to process my claims.

Signature of patient (or guardian)_____ Date _____

TexasVoiceCenter
Voice, Swallowing, and General ENT

C. Richard Stasney, MD, FACS
Apurva A. Thekdi, MD
6550 Fannin Street, Suite 2025
Houston, Texas 77030-2717
713-796-2181 713-796-2349 fax

RELEASE OF MEDICAL RECORDS

Date: _____

To: _____
Name

_____
Street

_____
City State ZIP

Re: Patient Name: _____ Birthdate:_____

Gender: _____ Social Security Number_____

Dear Dr. _____:

This letter will authorize you to provide a copy, summary, or narrative of my medical records (as indicated by the checkmark(s) below or otherwise release confidential information:

_____Complete record
_____Record of care from _____to_____, only
_____Record of care concerning the following condition(s)_____
_____
_____Other, Specify:_____
_____Confer with another person orally about information in my medical record

HIV/AIDS. I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS with the rest of my medical record.

Initial:_____ Date:_____

The reason or purpose for this release of information is as follows:_____
_____

I understand that you will provide this information within 15 days from receipt of request (per Medical Practice Act of the Texas State Board of Medical Examiners) and that a fee for preparing and furnishing this information may be charged. (The fee will be waived if the records are to be used for supporting an application for disability or other benefits or assistance under a) Aid to Families with Dependent Children, b) Medicaid, c) Medicare, d) Supplemental Security Income, and e) Federal Old-Age and Survivors Insurance. I have attached a statement that confirms that such an application or appeal has been filed or is pending.

Signed:_____ Date_____
(Patient or person legally authorized to consent on patient's behalf)

ACKNOWLEDGEMENT OF REVIEW OF
TEXAS VOICE CENTER, PLLC

NOTICE OF PRIVACY PRACTICES

I have reviewed the Notice of Privacy Practices of Texas Voice Center, PLLC, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____
Name of Patient

_____
Name of Patient's Representative

Relationship of Patient's Representative to Patient: _____

_____ _____
Signature of Patient or Patient's Representative Date

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Patient's Name _____ Date _____

Patient's Signature _____ Date _____

- -

If patient is a Minor :

Signature of parent or legal guardian _____ Date _____

TexasVoiceCenter
Voice, Swallowing, and General ENT

Smith Tower
6550 Fannin Street, Suite 2025
Houston, Texas 77030
713-796-2181 Fax: 713-796-2349

Directions to our Medical Center Office:

Smith Tower is located across from The Methodist Hospital on Fannin Street and opposite the Scurlock Tower on University Blvd. The building occupies the entire block at the intersection of Main St., University, and Fannin. Valet and self-parking areas can be accessed through any of the building's entrances. As parking is sometimes difficult to find, using the Valet parking service can be very convenient. The cost for Valet parking is the same as self-park plus any tip you may choose to give. Parking rates range from $5.00 (up to 2 hours), to $11.00 for 24-hour parking. Texas ENT Consultants does not validate parking tickets.

From the West:
Follow Interstate 10 east toward Houston; exit 610 south (past the Galleria), then merge onto 59 north (toward downtown Houston). Follow 59 north to the Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University Blvd. (Rice Stadium will be on the left); turn left onto University; follow University to Main Street. Smith Tower is the building across Main on the left side of the street. The parking lot is accessible from Main Street, University Blvd. and Fannin Street (although it is more difficult to enter from Fannin).

From the East:
Take Interstate 10 west toward Houston; exit onto 59 south toward Victoria. Follow 59 south to the Fannin Street exit, then follow Fannin south appx. 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman [Baylor Plaza] on your left). Smith Tower is on the right-hand corner of the next intersection (University Blvd). There in an entrance to Valet and self-park before the University intersection, at the NE corner of the building . There are additional entrances on University and on Main.

From the North:
On Interstate 45, head south to 59 south toward Victoria. Follow 59 south to the Fannin Street exit, then follow Fannin south appx. 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman Blvd [Baylor Plaza] on your left). Smith Tower is on the right-hand corner of the next intersection (University Blvd). There in an entrance to Valet and self-park before the University intersection, at the NE corner of the building . There are additional entrances on University and on Main.

From the Northwest:
Follow 290 southeast toward 610 south. Go past the Galleria, then merge onto 59 north (toward downtown Houston). Follow 59 north to the Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University Blvd. (Rice Stadium will be on the left); turn left onto University; follow University to Main Street. Smith Tower is the building across Main on the left side of the street. The parking lot is accessible from Main Street, University Blvd. and Fannin Street (although it is more difficult to enter from Fannin).

From the Northeast:
Follow 59 south toward Victoria; exit onto Fannin Street, then follow Fannin south appx. 2 miles (you will pass Hermann Park and Hermann Hospital, Ross Sterling Ave. and John Freeman Blvd [Baylor Plaza] on your left). Smith Tower is on the right-hand corner of the next intersection (University Blvd). There in an entrance to Valet and self-park before the University intersection, at the NE corner of the building . There are additional entrances on University and on Main.

From the South:
Take 288 north to 610 west. Follow 610 west to the Fannin Street exit. Turn right onto Fannin and stay to the right when the road splits. Proceed to University Blvd. (appx. the fourth intersection after the split, located directly in front of The Methodist Hospital); turn left onto University and enter the building's Valet/self-park area from the second driveway on the right.

From the Southwest:
Take 59 north toward Houston; exit at Greenbriar/Shepherd exit; turn right onto Greenbriar (first intersection); follow Greenbriar heading south several blocks to University Blvd. (Rice Stadium will be on the left); turn left onto University; follow University to Main Street. Smith Tower is the building across Main on the left side of the street. The parking lot is accessible from Main Street, University Blvd. and Fannin Street (although it is more difficult to enter from Fannin).

From the Southeast:
On Interstate 45 head north to 610 west. Follow 610 west to the Fannin Street exit. Turn right onto Fannin and stay to the right when the road splits. Proceed to University Blvd. (appx. the fourth intersection after the split, located directly in front of The Methodist Hospital); turn left onto University and enter the building's Valet/self-park area from the second driveway on the right.