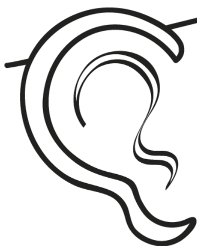

**Colorado Springs Ear Associates**

JOSEPH L. HEGARTY, M.D. OTOLOGY, NEUROTOLOGY & SKULL BASE SURGERY

Adult & Pediatric Ear Care | Hearing Aid & Cochlear Implant Center

Balance Disorders Center | Skull Base Surgery Center

1625 Medical Center Point, Suite 180
Colorado Springs, CO 80907
ph: 719.667.1327 (1EAR)
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# *HEARING & BALANCE QUESTIONNAIRE*

Name _________________________________________ Age _________ Date of Birth _______________ Date _________________

**I. DIZZINESS**: The following questions refer to your dizziness. If you are not experiencing dizziness, please skip to the next section.

Please describe in your own words the sensation you feel without using the word "dizzy."
____________________________________________________________________________________________
____________________________________________________________________________________________
____________________________________________________________________________________________

Is your dizziness more a "***lightheadednes***s" or a "***spinning***?" (Please circle one)

Is your dizziness "***intermittent***" or is it "***constan***t?" (Please circle one)

When you experience intermittent dizziness, does it last "***second***s" – "***minutes***" – " ***hours***" – "***days***" – "***weeks***?" (Please circle one)

When you experience intermittent dizziness, does it come on "***only when moving***" or "***even if perfectly still***?' (Please circle one)

The following refer to a typical dizzy spell. Please answer them as "yes" or "no" and fill in the blanks.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do the dizzy spells come in attacks? If yes, how often? ___________ how long do they last? _____________ How long have you been experiencing them? _________________________ |
| ☐ | ☐ | Are you free of dizziness between attacks? |
| ☐ | ☐ | Does your hearing change with an attack? Which ear? __________________ |
| ☐ | ☐ | Are you dizzy mainly when you sit up or stand up quickly? |
| ☐ | ☐ | Are you more dizzy in certain positions? Which positions? ________________________________ |
| ☐ | ☐ | Are you nauseated during an attack? |
| ☐ | ☐ | Are you dizzy even when lying down? |
| ☐ | ☐ | Did you have a cold or flu just before the dizziness started? |
| ☐ | ☐ | Do you notice fullness, pressure or ringing in your ears? Which side? __________________________ |
| ☐ | ☐ | Have you had pain or discharge in your ear recently? Which side? _____________________________ |
| ☐ | ☐ | Have you had difficulty walking in the dark? |
| ☐ | ☐ | Are you better if you sit or lie perfectly still? |

The following refer to other sensations you have. Please answer them as "yes" or "no" and fill in the blanks.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do you black out or faint when dizzy? |
| | | Have you had: |
| ☐ | ☐ | Severe or recurrent headaches? |
| ☐ | ☐ | Any double or blurry vision? |
| ☐ | ☐ | Numbness in your face or extremities? |
| ☐ | ☐ | Weakness or clumsiness in arms, legs? |
| ☐ | ☐ | Tingling around your mouth? |
| ☐ | ☐ | Spots before your eyes? |
| ☐ | ☐ | Jerking of arms or legs? |
| ☐ | ☐ | Seizures? |
| ☐ | ☐ | Confusion or memory loss? |
| ☐ | ☐ | Recent head trauma? If yes, please explain ________________________________________ |
| ☐ | ☐ | Do you have a lightheaded or a swimming sensation when you are dizzy? |
| ☐ | ☐ | Do you find yourself breathing faster or deeper when you are dizzy? |
| ☐ | ☐ | Did you recently change your eyeglasses? |
| ☐ | ☐ | Do you ever notice weakness or faintness a few hours after eating? |
| ☐ | ☐ | Have any medicines been helpful in reducing the dizziness? Please list. |

# Colorado Springs Ear Associates

**II.** **HEARING LOSS**: The following questions refer to your hearing loss. If you are not experiencing hearing loss, please skip.

Please describe in your own words, the problem you are experiencing with your hearing.

___

___

___

Did you notice your hearing loss "***suddenly***" or "***gradually***?" (Please circle one)

Is your hearing loss "***intermittent***" or "***constant***?" (Please circle one)

Is the hearing loss noticeable in the "***right***" – "***left***" – "***both***?" (Please circle one)

How long have you noticed your hearing loss? ____________________

The following refer to your hearing loss. Please answer them as "yes" or "no" and fill in the blanks.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Do other younger family members have a known hearing loss? |
| ☐ | ☐ | Older family members? |
| ☐ | ☐ | Have you ever experienced a noise loud enough to cause your ear to ring? |
| ☐ | ☐ | Do you shoot guns? If so, do you use ear protection? ____________ |
| ☐ | ☐ | Is your work environment very noisy? If yes, please explain ________________________________________ |
| ☐ | ☐ | Was there a specific event that you feel caused your hearing loss? If yes, please explain ___________________ |
| ☐ | ☐ | Have you had any previous ear infections? |
| ☐ | ☐ | Have you had any previous ear trauma? |
| ☐ | ☐ | Do you notice difficulty hearing in crowds? |
| ☐ | ☐ | Do you wear hearing aids? If yes, are you satisfied with them ______________________________________ |
| ☐ | ☐ | Have you ever had ear surgery? If yes, please list ______________________________________________ |

**III.** **EAR RINGING (TINNITUS)**: The following questions refer to your tinnitus. If you are not experiencing tinnitus, please skip.

Please describe in your own words, the problem you are experiencing with ear ringing.

___

___

___

Did you notice your tinnitus "***suddenly***" or a "***gradually***?" (Please circle one) How long have you noticed it? ____________

Is your tinnitus "***intermittent***" or "***constant***?" (Please circle one)

Is the tinnitus noticeable in the "***right***" – "***left***" – "***both***" – "***In head***?" (Please circle one)

Circle the best description(s) of your tinnitus: Ring Sizzle Hiss Hum Crackle Crickets Static Motor

Ocean Transformer line Waterfall Popping Heartbeat Clicking

On a scale of 0 – 10, please circle the loudness of your tinnitus (0 – can't hear it, 10 – very loud):

0 1 2 3 4 5 6 7 8 9 10

The following refer to your tinnitus. Please answer them as "yes" or "no" and fill in the blanks.

| Yes | No | |
|---|---|---|
| ☐ | ☐ | Does the tinnitus keep you awake at night? |
| ☐ | ☐ | Did the tinnitus start after: |
| ☐ | ☐ | Beginning a new medication? If so, which medicine ________________________________________ |
| ☐ | ☐ | Exposure of an intense sound? If so, please explain ________________________________________ |
| ☐ | ☐ | Head or neck injury? If so, please explain ______________________________________________ |
| ☐ | ☐ | Infection of the ear or sinus? |
| ☐ | ☐ | Do you feel irritable because of your tinnitus? |
| ☐ | ☐ | Does your tinnitus interfere with your overall enjoyment of life? |
| ☐ | ☐ | Is the tinnitus louder after eating salty foods or drinking caffeinated beverages? |

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## *MEDICAL QUESTIONNAIRE*

**MEDICAL HISTORY**: Check any medical problems you have been or are being treated for (include year of diagnosis).

| | | | |
|---|---|---|---|
| ☐ High Blood Pressure | ☐ Visual loss | ☐ Psychiatric problems | ☐ Head injury |
| ☐ Heart Disease | ☐ Migraines | ☐ Arthritis | ☐ Neck injury |
| ☐ Heart Attack | ☐ Anemia | ☐ Thyroid problems | ☐ Joint replacements |
| ☐ Irregular heart beat | ☐ Cancer | ☐ Radiation to head/neck | ☐ |
| ☐ Seizures | ☐ Diabetes | ☐ Asthma/COPD | ☐ |
| ☐ Stroke | ☐ Brain tumors | ☐ Allergies/Sinus | ☐ |

How would you rate your overall health? Excellent Good Fair Poor

**SURGICAL HISTORY**: Please note all the surgeries & procedures you have had (include year of surgery).

| | | | |
|---|---|---|---|
| ☐ Tonsils & Adenoids | ☐ Stapedectomy | ☐ Tympanoplasty | ☐ |
| ☐ Ear tubes | ☐ Ossiculoplasty | ☐ Mastoidectomy | ☐ |

**OTOLOGIC HISTORY**: Please check if you have had exposure to any of the items below (include year of exposure).

| | |
|---|---|
| ☐ Excessive noise (explain) | ☐ Meningitis |
| ☐ Gun shooting | ☐ High doses of aspirin or Motrin |
| ☐ Prolonged IV antibiotics (Gentamycin, Vancomycin) | ☐ Quinine for malaria |
| ☐ Cancer chemotherapy | ☐ Head injury |

**SOCIAL HISTORY**:

What is your current occupation? ________________________________________

| | | | | | | |
|---|---|---|---|---|---|---|
| Do you smoke? | No | Yes | ________ | packs/day | ________ | year quit |
| Do you drink alcohol? | No | Yes | ________ | drinks/week | ________ | (type of alcohol used) |
| Do you use caffeine? | No | Yes | ________ | cups/day | ________ | (coffee, tea, soda) |

Are you currently disabled? No Yes Reason for disability ________________________________

**ALLERGIES TO MEDICATIONS**: Please state the reaction you have had to each medicine.

| | |
|---|---|
| 1. | 3. |
| 2. | 4. |

**MEDICATIONS**: Please give us a complete list of all the medicine you take (please include strength and how often it is taken).

| | |
|---|---|
| 1. | 6. |
| 2. | 7. |
| 3. | 8. |
| 4. | 9. |
| 5. | 10. |

**FAMILY HISTORY**: Check if any blood relative has had any of the following. Indicate which relative.

| | | | |
|---|---|---|---|
| ☐ Ear deformities | ☐ Kidney failure | ☐ Diabetes | ☐ Bleeding |
| ☐ Meniere's Disease | ☐ Migraines | ☐ Blindness | ☐ Anesthesia reactions |
| ☐ Seizures | ☐ Thyroid problems | ☐ Total deafness | ☐ High Blood Pressure |
| ☐ Stroke | ☐ Cancer | ☐ Hearing loss | ☐ |

# Colorado Springs Ear Associates

**SYSTEM REVIEW** (Next Page): Please check conditions that apply to your current health:

GENERAL

| Y | N | |
|---|---|---|
| ☐ | ☐ | Fever |
| ☐ | ☐ | Weight Loss |
| ☐ | ☐ | Decreased Appetite |
| ☐ | ☐ | Excessive Fatigue |

EYES

| Y | N | |
|---|---|---|
| ☐ | ☐ | Wear Glasses |
| ☐ | ☐ | Glaucoma |
| ☐ | ☐ | Cataracts |
| ☐ | ☐ | Infections |
| ☐ | ☐ | Injuries |

EAR, NOSE, THROAT, MOUTH

| Y | N | |
|---|---|---|
| ☐ | ☐ | Wear hearing aids |
| ☐ | ☐ | Nose bleeds |
| ☐ | ☐ | Congestion |
| ☐ | ☐ | Inability to smell |
| ☐ | ☐ | Sinus |
| ☐ | ☐ | Sinus headaches |
| ☐ | ☐ | Sore throat |
| ☐ | ☐ | Mouth sores |
| ☐ | ☐ | Hoarseness |
| ☐ | ☐ | Difficulty swallowing |

CARDIOVASCULAR

| Y | N | |
|---|---|---|
| ☐ | ☐ | Chest pain/angina |
| ☐ | ☐ | High blood pressure |
| ☐ | ☐ | Irregular pulse |
| ☐ | ☐ | Heart murmur |
| ☐ | ☐ | High cholesterol |
| ☐ | ☐ | Swelling hands/feet |
| ☐ | ☐ | Leg pain while walking |
| ☐ | ☐ | Pacemaker |

PSYCHIATRIC

| Y | N | |
|---|---|---|
| ☐ | ☐ | Depression |
| ☐ | ☐ | Anxiety |
| ☐ | ☐ | Mental Illness |
| ☐ | ☐ | Sleeping difficulty |

ENDOCRINE

| Y | N | |
|---|---|---|
| ☐ | ☐ | Diabetes |
| ☐ | ☐ | Thyroid disease |
| ☐ | ☐ | Hormone problems |
| ☐ | ☐ | Increased thirst/urination |
| ☐ | ☐ | Increased appetite |

RESPIRATORY

| Y | N | |
|---|---|---|
| ☐ | ☐ | Asthma |
| ☐ | ☐ | Emphysema |
| ☐ | ☐ | Bronchitis |
| ☐ | ☐ | Chronic cough |
| ☐ | ☐ | Shortness of breath |
| ☐ | ☐ | Pneumonia |
| ☐ | ☐ | Bloody sputum |
| ☐ | ☐ | Lung cancer |
| ☐ | ☐ | Tuberculosis |

Date of last chest x-ray_________

GASTROINTESTINAL

| Y | N | |
|---|---|---|
| ☐ | ☐ | Regular nausea/vomiting |
| ☐ | ☐ | Blood in vomit |
| ☐ | ☐ | Heartburn |
| ☐ | ☐ | Gallbladder problems |
| ☐ | ☐ | Hernia |
| ☐ | ☐ | Abdominal pain |
| ☐ | ☐ | Ulcer / gastritis |
| ☐ | ☐ | Change in bowel habits |
| ☐ | ☐ | Liver disease |
| ☐ | ☐ | Jaundice |
| ☐ | ☐ | Diverticulitis |
| ☐ | ☐ | Irritable bowel/Colitis |
| ☐ | ☐ | Hemorrhoids |
| ☐ | ☐ | Colon cancer |

GENITOURINARY

| Y | N | |
|---|---|---|
| ☐ | ☐ | Urinary tract infection |
| ☐ | ☐ | Painful urination |
| ☐ | ☐ | Blood in urine |
| ☐ | ☐ | Loss of bladder control |
| ☐ | ☐ | Kidney stones |
| ☐ | ☐ | Sexually transmitted disease |
| **Males** | | |
| ☐ | ☐ | Prostate problems |
| **Females** | | |
| ☐ | ☐ | Menstrual flow / irregular |
| ☐ | ☐ | Menopause |
| ☐ | ☐ | Uterine/Cervical cancer |
| ☐ | ☐ | Breast pain |
| ☐ | ☐ | Use birth control |

Type of oral contraceptive ____________
Date of last PAP___________________
Date of last mammogram______________

ALLERGIC/IMMUNOLOGIC

| Y | N | |
|---|---|---|
| ☐ | ☐ | Food allergies |
| ☐ | ☐ | Inhalant allergies |
| ☐ | ☐ | Immune disorders |

HEMATOLOGICAL/LYMPHATIC

| Y | N | |
|---|---|---|
| ☐ | ☐ | Anemia |
| ☐ | ☐ | Bleeding tendencies |
| ☐ | ☐ | Phlebitis |
| ☐ | ☐ | Enlarged lymph nodes |
| ☐ | ☐ | Blood transfusion |

When? _______________

MUSCULOSKELETAL

| Y | N | |
|---|---|---|
| ☐ | ☐ | Back/neck pain |
| ☐ | ☐ | Arm/leg pain |
| ☐ | ☐ | Joint pain/swelling |
| ☐ | ☐ | Arthritis |
| ☐ | ☐ | Broken bones |
| ☐ | ☐ | Osteoporosis |

INTEGUMENTARY

| Y | N | |
|---|---|---|
| ☐ | ☐ | Skin disease/Type_________ |
| ☐ | ☐ | Rashes/Where___________ |

NEUROLOGICAL

| Y | N | |
|---|---|---|
| ☐ | ☐ | Fainting/blackout spells |
| ☐ | ☐ | Seizures |
| ☐ | ☐ | Memory problems |
| ☐ | ☐ | Disorientation/confused |
| ☐ | ☐ | Concentration problems |
| ☐ | ☐ | Difficulty with speech |
| ☐ | ☐ | Double/blurred vision |
| ☐ | ☐ | Facial weakness |
| ☐ | ☐ | Headaches |
| ☐ | ☐ | Stroke |
| ☐ | ☐ | Muscle weakness |
| ☐ | ☐ | Numbness/tingling |
| ☐ | ☐ | Tremors/hand shaking |
| ☐ | ☐ | Eat salty foods |
| ☐ | ☐ | Add salt to your food |
| ☐ | ☐ | Eat out frequently |
| ☐ | ☐ | Drink coffee, tea, sodas |

How much? ________________

| | | |
|---|---|---|
| ☐ | ☐ | Drink alcohol |

How much? ________________

| | | |
|---|---|---|
| ☐ | ☐ | Smoke cigarettes |

How much? ________________

| | | |
|---|---|---|
| ☐ | ☐ | Exercise regularly |

Type? _____________________

| | | |
|---|---|---|
| ☐ | ☐ | Other Medical problems |

___________________________
___________________________
___________________________
___________________________

| | | |
|---|---|---|
| ☐ | ☐ | Living Will |
| ☐ | ☐ | Advanced Directives |

Patient Signature ____________________________________ Date ___________________________

Physician Signature ____________________________________ Date reviewed _________________
_________________
_________________
_________________

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# Financial Policy & Privacy Practices

1. **Patient with Insurance.** You are responsible for deductibles, co-pays, non-covered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payment and coinsurance amounts as services are rendered. The remaining balance should be taken care of 30 days after receipt of payment from the insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted.
2. **Patient without Insurance (private pay).** Please make payment for your care at each patient visit.
3. **Worker's Compensation Patient.** As a Worker's Compensation patient, you may be covered by insurance if your injury is reported at work and verified with your employer. Please be sure to inform the office personnel that injury resulted during employment. The patient is ultimately responsible for the balance due.
4. **Medicare.** Our office will submit your Medicare charges to Medicare and your secondary insurance, if applicable. You are responsible for deductibles, co-pays, and any non-covered services.

# Guarantee of Payment

1. I understand that I am totally responsible for payment of all fees and services rendered, irrespective of insurance coverage or other responsibilities.

   **NOTE: The guarantor of each account is ultimately responsible for payment in full of the account. As a courtesy to you, we will bill your primary insurance. If insurance does not pay in a timely manner (within 90 days from the date of service and insurance filing), the insured will be expected to pay the balance and then pursue reimbursement from their insurance company.**
2. I have been advised that if my health insurance carrier / HMO / Medicaid / Medicare plan claims that the services I received today are not considered reasonable and medically necessary for my care, I will be responsible for payment of these services.
3. I understand that if I am participating in an HMO plan, my primary care physician (PCP) must authorize the services that I requested and received today. I have been advised that if I did not notify my PCP in advance for a referral authorization, my HMO plan may deny payment for services and thus, I will become responsible for payment of all services.
4. I understand there is a $25 fee for any returned check for NSF (Non-sufficient funds).

# Assignment

1. I assign the benefits from my insurance carriers to this office for the medical/surgical benefits I am entitled.
2. I request that payment of authorized Medicare benefits be made on my behalf to Colorado Springs Ear Associates (CSEA) for any service furnished to me by these providers.

# Release of Information

1. I authorize CSEA to release to my insurance carrier(s) any information needed to determine benefits or benefits payable for related services.
2. I authorize CSEA to release any information in the course of my evaluation and treatment to my Primary Care Physician.
3. I authorize any physician, hospital, laboratory or x-ray facility to release to CSEA any and all medical information, hospital records, laboratory studies or x-rays that may be requested. A copy of this authorization is as binding as the original.

# Acknowledgement of Receipt of Privacy Practices

________ I have reviewed a copy of Privacy Practices (HIPPA) for CSEA (***Please initial***).

________ I authorize a representative of CSEA to discuss my private health information with the following person (***Please initial***):

Name ________________________________ Name ________________________________

Relationship ____________________________ Relationship ____________________________

X______________________________________________________
Patient Signature Date

______________________________ ______________________________
Patient Name (please print) Person signing on behalf of patient (state relationship)