Duncan Hearing Healthcare

1822 N. Main St • Ste 201 • Fall River, MA 02720
P: 508.674.3334 • F: 508.674.5855 • duncanhearing.com

NANCY DUNCAN Au.D.
Doctor of Audiology

ALICIA O'SULLIVAN Au.D.
Doctor of Audiology

Dear Patient:

Enclosed you will find a form(s) that <u>will</u> need to be completed prior to your appointment on:

_____at_____am/pm

If your insurance requires a referral for your visit you will need to contact your Primary Care Physician. Please note that referrals need to be in our office prior to your appointment. Your may have your doctor call our office or fax your referral to (508) 674.5855. If you are unsure of whether or not you will need a referral you will need to contact your doctor. Please bring your insurance card(s) with you to your appointment. **Please be advised there is a <u>$65.00 patient responsibility</u> towards testing that insurance does not cover. <u>This is due at the time of your office visit.</u>**

- **If you are coming in for Balance / Dizziness Testing please be sure to read all of the enclosed paperwork carefully as there are instructions you will need to follow prior to your visit.**
- **Also please be advised if you are coming for Balance / Dizziness Testing it will take between 1-2 hours.**
- **Please be advised there is a medication list that <u>MUST</u> be filled out with all of your medications and dosages.**

We look forward to seeing you at your appointment and if you have any questions please contact our office at (508) 674.3334.

Sincerely,
Duncan Hearing Healthcare

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You will be instructed to refrain from taking certain medications for 48 hours prior to your test date. Certain medications can influence the body's response to the test, thus giving a false or misleading result. You will find a short list below, however if you have any questions or concerns about discontinuing certain medications please consult your primary care physician. If he/she fells that you are unable to cease taking the medications please let the examiner know on the date of the visit. Please refrain from taking the following medications 48 hours prior to your visit:

Alcohol:	beer, wine, wine coolers hard liquors, mixed drinks and cough medicine.
Analgesics-Narcotics:	Codeine, Demerol, Phenaphen, Tylenol with Codeine, Percocet, Darvocet
Anti-histamines:	Chlor-trimeton Dimetapp, Dispphrol, Benadryl, Actifed, Teldrin, Triaminic, Hismanol, Claritin... any over-the-counter cold remedies.
Anti-seizure medication:	Dilantin, Tegretol and Phenobarbital
Anti-vertigo medicine:	Atarax, Dramamine, Compazine, Antivert, Bucladin, Phenergan, Thorazine, Scopalomine, Transdermal
Sedatives:	Halcion, Restoril, Nembutal, Seconal, Dalmane, or any sleeping pill.
Tranquilizers:	Valium, Librium, Atarax, Vistaril, Serax, Ativan, Librax, Tranxene, Xanax etc...

PLEASE DO NOT WEAR EYE MAKE-UP

Dress comfortably, women may wish to wear slacks. If you wear contact lenses please bring your glasses with you in case you need to remove your lenses. You may also with to bring your eyeglass holder. •••You may take blood pressure medications, heart medications, thyroid medication, Tylenol, insulin, estrogen etc. Antidepressants such as Prozac, Paxil, Effexor, Zoloft, Celexa and Wellbutrin should NOT be stopped. Always consult with your physician before discontinuing any prescribed medication.•••

Please eat lightly for 12 hours prior to your appointment. If your appointment is in the morning you may have a light breakfast such as toast and juice. If your appointment is in the afternoon, eat a light breakfast and have a light snack for lunch. **Please avoid caffeniated beverages such as coffee and soft drinks 5 hours prior to your testing.**

Testing may causes a sensation of motion that may linger. If possible we encourage you to have someone accompany you to and from the appointment, however, if this is not possible try to plan your day to include an extra 15 to 30 minutes after your test before leaving the office.

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Name: | Male ☐ | Female ☐
Address:
Apt/Suite: | City:
State:
Home Phone:
Work Phone: | EXT:
SS#: - -
Marital Status:
D.O.B.: / / | Age:
EMERGENCY, CONTACT:
Phone:

Employment Status:

Full Time: ☐ | Part Time: ☐ | Retired: ☐ | None: ☐
Employer:
Address:
Apt/Suite: | City:
State: | Zip:

Medical Doctor Information:

Referring Dr:
Phone:
Address:
Apt/Suite: | UPIN: | City:
State: | Zip:
Family Dr:
Phone:

PLEASE STATE BRIEFLY THE NATURE OF YOUR PROBLEM:

PLEASE LIST MEDICATIONS YOUR ARE TAKING:

PLEASE LIST OPERATIONS YOU HAVE HAD:

PLEASE NAME ANY MEDICATIONS YOU ARE ALLERGIC TO OR HAVE BEEN ADVISED NOT TO TAKE:

PLEASE CHECK ANY OF THE FOLLOWING YOU HAVE HAD OR NOW HAVE:

☐ Heart Disease	☐ Glaucoma	☐ Stroke	☐ Nausea	☐ Artificial Joints
☐ Ulcer Disease	☐ Depression	☐ Cancer	☐ Back Problems	☐ Multiple Sclerosis
☐ Blood Disorders	☐ Pacemaker	☐ Asthma	☐ Neck Problems	☐ Emphysema /COPD
☐ Infection / Wounds	☐ Tuberculosis	☐ Arthritis	☐ Breathing problems	☐ High Blood Pressure
☐ Parkinson's Disease	☐ Ringing in Ears	☐ Diabetes	☐ Circulation Problems	☐ Epilepsy/Convulsions

AUTHORIZATION FOR TREATMENT

The Patient/legal guardian authorizes ENTER PRACTICE NAME HERE staff to administer appropriate testing and/or treatment for the patient's diagnosis/rehabilitation. The patient/legal guardian agrees that no guarantee or assurance has been made as to the results that may be obtained from the services rendered.

Signature_____ Date _____

AUTHORIZATION FOR PAYMENT

I authorize my referring physician to file a claim to my insurer on my behalf for services provided at ENTER PRACTICE NAME HERE I understand that all medical benefits, co-payments and deductibles will be issued directly to the referring physician.

Signature_____ Date _____

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Patient Questionnaire

Patient Name: _____ Date: _____
(Last) (First)

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? _____

How long did it last? _____

I. Do you experience any of the following sensations? Please read the entire list first. Then either circle YES or circle NO to describe your feelings most accurately.

1.	Do you experience motion sickness, airsickness or seasickness?	**Yes / No**
2.	Did you have motion sickness as a child?	**Yes / No**
3.	Do you have a family history of motion sickness?	**Yes / No**
	If so, parents?	**Yes / No**
	If so, siblings?	**Yes / No**
	If so, child?	**Yes / No**
4.	Do you have migraine headaches?	**Yes / No**
5.	Were you exposed to any solvents, chemicals, etc?	**Yes / No**
6.	Did you have any injuries to your head?	**Yes / No**
	When? _____	
7.	If you received a head injury, were you unconscious?	**Yes / No**
8.	Have you ever had a neck injury?	**Yes / No**
9.	Have you ever fallen?	**Yes / No**
	How many times? _____	
	Where? Were you inside or outside of home? _____	
10.	Are you afraid of falling?	**Yes / No**
11.	Do you take any medications regularly? (i.e. tranquilizers, oral contraceptives, barbiturates, antibiotics, thyroid)	**Yes / No**
	What kinds? _____	
12.	Do you use alcohol?	**Yes / No**
13.	Do you smoke?	**Yes / No**
	How much? _____	

Patient Questionnaire Continued

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II. If you have dizziness, please circle YES and fill in the blank spaces. If you do not experience dizziness, please go to the next section (III).

1.	My dizziness is constant? If you answered yes, please go to section III.	**Yes / No**
2.	If in attacks, how often?	
3.	Are you completely free of dizziness between attacks?	**Yes / No**
4.	Do you have any warning that the attack is about to start?	**Yes / No**
5.	Is the dizziness provoked by head/body movement? If so, which direction?	**Yes / No**
6.	Is the dizziness better or worse at any particular time of the day?	**Yes / No**
	If so, when?	
7.	Do you know of anything that will stop your dizziness or make it better?	**Yes / No**
	What?	
8.	Do you know of anything that will make your dizziness worse?	**Yes / No**
	What?	
9.	Do you know of anything that will precipitate an attack?	**Yes / No**
	What?	
10.	Do you know any possible cause of your dizziness?	**Yes / No**
	What?	

III. Do you experience any of the following sensations? Please read the entire list first then circle either YES or NO to describe your feelings most accurately.

1.	Light headedness?	**Yes / No**
2.	Swimming sensation in the head?	**Yes / No**
3.	Blacking out or loss of consciousness?	**Yes / No**
4.	Objects spinning or turning around you?	**Yes / No**
5.	Sensation that you are turning or spinning inside, with outside objects remaining stationary?	**Yes / No**
6.	Tendency to fall to the right or left?	**Yes / No**
7.	Tendency to fall to the forward or backward?	**Yes / No**
8.	Loss of balance when walking, veering to the right?	**Yes / No**
9.	Loss of balance when walking, veering to the left?	**Yes / No**
10.	Nausea or vomiting?	**Yes / No**
11.	Pressure in the head?	**Yes / No**

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IV. Have you ever experienced any of the following symptoms? Please circle either YES or NO and if Constant or if In Episodes.

1.	Double vision?	**Yes / No**	**Constant / In Episodes**
2.	Blurred vision or blindness?	**Yes / No**	**Constant / In Episodes**
3.	Spots before your eyes?	**Yes / No**	**Constant / In Episodes**
4.	Numbness of face, arms or legs?	**Yes / No**	**Constant / In Episodes**
5.	Weakness in arms or legs?	**Yes / No**	**Constant / In Episodes**
6.	Confusion or loss of consciousness?	**Yes / No**	**Constant / In Episodes**
7.	Difficulty in swallowing?	**Yes / No**	**Constant / In Episodes**
8.	Tingling around the mouth?	**Yes / No**	**Constant / In Episodes**
9.	Difficulty speaking?	**Yes / No**	**Constant / In Episodes**

V. Do you have any of the following symptoms? Please circle either YES or NO and circle the ear involved.

1.	Difficulty in hearing?	**Yes / No**	**Both Ears**	**Right Ear**	**Left Ear**
	When did this start?				
2.	Is hearing getting worse?	**Yes / No**			
3.	Does the hearing change with your symptoms?	**Yes / No**			
	If so, how?				
4.	Noise in your ears?	**Yes / No**	**Both Ears**	**Right Ear**	**Left Ear**
	Describe the noise:				
	Does the noise change with your symptoms?				
	If so, how?				
5.	Does anything stop the noise or make it better?	**Yes / No**			
	If so, what?				
6.	Fullness or stuffiness in your ears?	**Yes / No**	**Both Ears**	**Right Ear**	**Left Ear**
	Does this change when you are dizzy?	**Yes / No**			
7.	Do you have pain in your ears?	**Yes / No**	**Both Ears**	**Right Ear**	**Left Ear**
8.	Do you have discharge from your ears?	**Yes / No**	**Both Ears**	**Right Ear**	**Left Ear**

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Patient Medications

Patient Name: _____ Date: _____
(Last) (First)

Please list all your current medications that you are currently taking:

Name of Drug	Dosage	Frequency	Route