COLE AUDIOLOGY LAB
Human Services Bldg. Room 205
P.O. Box 13019, SFA Station
Nacogdoches, TX 75962- 3019
F: 936.468.7096
P: 936.468.7109

Adult Hearing History

Name:_____ DOB: _____

Age:_____ Gender:_____ Phone:_____ Cell:_____

Address:_____

City:_____ State: _____ Zip: _____

Employer:_____

Spouse: _____ Spouse's employer: _____

Your Physician: _____

Person who referred you to Cole Audiology Lab:_____

List place where you have had previous hearing evaluations, include date:

_____

_____

Describe your hearing problem: _____

_____

What do you think caused your hearing problem?_____

_____

How long have you had this difficulty? _____

Has it changed recently? If so, please describe:_____

Have you ever had ear surgery? If yes, describe: _____

Is one ear better than the other? If so, which one? _____

Revised February 23, 2018

Do you have a feeling of discomfort/pain/pressure in your ears? _____

Do you hear ringing or other noises in your ears? Yes No

If yes, which ear and how often? Right Left Both Constant or Occasional

Are you especially sensitive to loud sounds? Yes No

Have you been exposed to loud sounds on a frequent basis (military, occupational, hunting, etc.? If so, describe: _____

Do you have sensations of dizziness or spinning? Yes No If yes, please describe

_____

Do any of your family members have a hearing problem? Yes No If so, please state relationship and describe: _____

Have you ever worn a hearing aid? Yes No (How many years?) _____

Are you wearing a hearing aid now? Yes No (Right Left Both) _____

Do you have difficulty hearing in the following areas? If so, please describe

Job:

_____

Family:

_____

Social:

_____

Describe any additional physical or medical problems you feel may be important to share:

_____

_____

What would you like to know from this evaluation about your hearing?

_____

_____

_____ _____

Signature Date

Revised February 23, 2018

Stephen F. Austin State University
Cole Audiology Lab

Information Regarding Protected Health Information

I have read the Notice of Health Information Practices provided by the Stephen F. Austin State University Cole Audiology Lab. I understand how the Audiology Lab will utilize my protected health information (PHI) and my rights regarding my protected health information.

Payment Responsibility

We request that office visits be paid at the time service is rendered. Any unpaid balance is due within 30 days regardless of insurance claim status, unless otherwise specified.

I understand that I am responsible for all charges for the services rendered to me or my dependents regardless of insurance.

_____ _____

Client or Parent/Guardian *Date*

Revised February 23, 2018

AUTHORIZATION FOR RELEASE OF INFORMATION

PROTECTED HEALTH INFORMATION

I have read the Notice of Health Information Practices provided by the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. I understand how the clinic will utilize my or my child's protected health information (PHI) and my rights regarding my protected health information.

_____ _____

Client or Legal Guardian *Date*

I undersigned, authorized the Stephen F. Austin State University Stanley Center for Speech and Language Disorders to acquire and/or release professional information to:

_____

Agency/Individual Name

_____

Address

_____

Phone Number

For the purpose of:

_____

_____

I authorize release of the following:

_____

_____

I understand that I may revoke this authorization by submitting a written request to the Stephen F. Austin State University Stanley Center for Speech and Language Disorders. Such a revocation does not apply to releases prior to the date of the request.

_____ _____

Client or Legal Guardian *Date*

Revised February 23, 2018