



NEWPORT-MESA AUDIOLOGY, BALANCE AND EAR INSTITUTE

Dr. Howard T. Mango, Au.D. Ph.D.

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PATIENT INFORMATION (Please complete all entries.)

Patient Name (Last / First / Middle) Mr. / Ms. / Mrs.		Sex M F	Date of Birth	Age	Social Security Number
Address (Street / City / State / Zip)		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
		Driver's License Number			
		Home Phone No. ()			
Name of Employer	Occupation	Work Phone No. ()			
Employer's Address (Street / City / State / Zip)					
Name of Spouse (Last / First / Middle)		Date of Birth	Age	Social Security Number	
Spouse's Employer		Spouse's Work Phone No. ()			
Nearest Relative Not Living With You		Relative's Phone No. ()			
In Case of Emergency, Notify:		Emergency Contact's Phone No. ()			
Whom May We Thank For Referring You to Us?		Phone No. ()			
Who is Financially Responsible for Payment?		I Will Be Paying Today By: <input type="checkbox"/> Check <input type="checkbox"/> Cash <input type="checkbox"/> Visa <input type="checkbox"/> Mastercard <input type="checkbox"/> Insurance			

INSURANCE INFORMATION

Primary Insurance Name	Address (City / State / Zip)		Phone No. ()
Name of Insured	Relationship	I.D. No.	Group No.
Secondary Insurance Name	Address (City / State / Zip)		Phone No. ()
Name of Insured	Relationship	I.D. No.	Group No.

I understand and agree that I am ultimately responsible and liable for amount not paid by my insurance company.

Signature

Date

I authorize payment of medical benefits to:

Newport-Mesa Audiology & Ear Institute, Inc., Howard T. Mango, Au.D., Ph.D., 500 Newport Blvd., Suite 101, Newport Beach, CA 92663

Signature

Date

I authorize release of any medical information necessary to process this claim.

Signature

Date

I understand that under the Medicare and/or Medicare supplemental insurance payment plan, I am liable for Medicare deductible for the year. I am also liable for supplemental insurance amount only if the supplemental insurance company sends the check to insured.

Signature

Date



HEALTH QUESTIONNAIRE (Please complete all entries.)	Date
Patient Name (Last / First / Middle)	Social Security Number

A. Reason for Visit

B. Medication

1. List all medications that you are taking. Include over-the-counter drugs.

Name	Strength	Frequency

Do you have any allergies to medications? No Yes I don't know. If known, please list below:

C. Medical History: List all medical conditions. If applicable, list the year and the reason for any hospital admissions.
(Do not include normal pregnancies.)

Year	Conditions / Illness / Operations

D. Miscellaneous Information: Please check appropriate box and give amount.

- 1. Do you smoke? No Yes _____ packs per day
- 2. Do you drink alcohol? No Yes _____ glasses per day, week, month
- 3. Do you drink caffeine products (tea, coffee, cola) No Yes _____ cups per day, week, month

E. Family History

1. List all family members with a history of hearing loss or ear problems.

Relationship	Age	Type of Hearing Loss / Ear Problem

2. Please circle any of the following diseases which are common in your family, or have occurred in any family member. (This does not include family members by marriage or adoption.)

- | | | | |
|---------------------|---------------|---------------------|------------------------|
| asthma | diabetes | high blood pressure | surgical complications |
| auto immune disease | hay fever | kidney disease | stroke |
| bleeding disorder | heart disease | migraine | tuberculosis |
| cancer | | | |

F. Symptom Review: Please circle to indicate if you have had any of the following symptoms or diseases.

Neurological

stroke
migraine
blackout spells
weakness or paralysis
terror / hand shaking
head injury
numbness / tingling sensations
muscle pains
significant arthritis
muscle irritation / tenderness

Respiratory

pneumonia
tuberculosis
asthma
chronic cough
shortness of breath

Blood / Lymphatic

bleeding disorder
anemia
previous transfusions
easy bruising

Head and Neck

dry mouth
headaches
glaucoma
itching eyes or nose
hay fever
sneezing or runny nose
sinus trouble
dry eyes
eye diseases or poor vision

Genital / Urinary

pneumonia
kidney disease
prostate problems anxiety
kidney stones
blood in urine

Gynecological

pregnancy
currently breast feeding
vaginitis

Infectious

AIDS
HIV positive
venereal disease
syphilis
gonorrhea
tuberculosis
chicken pox
German measles
mumps

Emotional

nervous breakdown
depression
chronic fatigue
suicidal tendencies

Dermatologic

rashes
boils
eczema
psoriasis
sun sensitivity

Endocrine

hormone therapy
thyroid
diabetes

Gastrointestinal

constipation
diarrhea
ulcer
heart burn
liver disease
pancreatitis

Cardiovascular

heart attack
angina / chest pain
any heart trouble
heart murmur
arythmia
high blood pressure
rheumatic fever

General

cancer

G. Ear Disease: Please circle Yes or No

- Yes No 1. Have you had your hearing tested
- Yes No 2. Have you ever been to a doctor for ear trouble?
- Yes No 3. Have you ever had ear surgery?
- Yes No 4. Have you ever worn hearing aids?
- Yes No 5. Do you wear hearing aids now?
- Yes No 6. Have any blood relatives with a hearing loss?
- Yes No 7. Today, do you have any of the following?
- (circle one) Allergies? Cold? Dizziness? Ear Pressure? Ear Drainage? Ear Infection? Ear Pain?
- Yes No 8. Are you bothered by ringing noises?
- Yes No 9. Are you now taking more than a few aspirins a day?
- Yes No 10. Have you ever taken large doses of aspirin? Anacin, Bufferin, Emperin, or Quinine? How many? _____ / day
- Yes No 11. Have you ever taken medications known to be damaging to your ears?
- Yes No 12. Have you ever received injections of any antibiotics of the mycin family? (gentamycin, kanamycin, vancomycin)
- Yes No 13. Do you have ear drainage or pain?
- Yes No 14. Have you ever suffered a severe head injury?
- Yes No 15. Have you ever had any of the following? (circle which)
- diabetes head injury measles mumps ear surgery kidney infections meningitis scarlet fever

Did you ever or do you now participate in (or use) any of the following? (answer each)

- Yes No 16. Motorcycling
- Yes No 17. Target shooting
- Yes No 18. Hunting
- Yes No 19. Snowmobiling
- Yes No 20. Auto racing
- Yes No 21. Power tools
- Yes No 22. Musical instruments
- Yes No 23. Private airplanes
- Yes No 24. Any job that is noisy
- Yes No 25. Farm equipment
- Yes No 26. Chainsaws
- Yes No 27. Were you in the military service or national guard?

What was your job? _____

- Yes No 28. Have you in your job or hobbies, been exposed to loud noise levels? (machinery, gun fire, rock music, etc.)
- Yes No 29. Do you wear hearing protection away from work? When started? _____
- Yes No 30. Were you working around loud noise during the last 14 hours?
- Yes No 31. Were you wearing hearing protection prior to this test today?
- Yes No 32. Do you have trouble understanding in crowds, in church or at meetings?
- Yes No 33. Do you have trouble understanding speech on the telephone?
- Yes No 34. Do you understand speech less than you did 5 years ago?
- Yes No 35. Do you have difficulty listening to music?

36. How is your hearing?
 Good Fair Poor



DIZZINESS QUESTIONNAIRE (Please complete all entries.)		Date	
Patient Name (Last / First / Middle)		Age	Sex

1. Please describe your symptoms: _____

2. When did these symptoms begin? _____

3. Did your symptoms come on gradually or suddenly? _____

4. Have symptoms become worse (More frequent? More severe?) or have they improved? _____

5. Check all that apply to your dizzy spells:

- | | |
|---|---|
| <input type="checkbox"/> Preceded by flu/cold | <input type="checkbox"/> Better if sit or lie still |
| <input type="checkbox"/> Spinning Sensation | <input type="checkbox"/> Fullness/pressure/ringing in the ears |
| <input type="checkbox"/> Falling on one side: Which side? _____ | <input type="checkbox"/> Imbalance when walking. Veering to which side? _____ |
| <input type="checkbox"/> Trouble walking in the dark | <input type="checkbox"/> Comes in attacks:
How often? _____ |
| <input type="checkbox"/> No symptoms between attacks | How long do they last? <input type="checkbox"/> Seconds <input type="checkbox"/> Minutes <input type="checkbox"/> Hours <input type="checkbox"/> Days |
| <input type="checkbox"/> Nausea | When was the last? _____ |
| <input type="checkbox"/> Vomiting | <input type="checkbox"/> More dizzy in certain positions: Which positions? _____ |
| <input type="checkbox"/> Perspiration, shortness of breath, or feeling of panic | |
| <input type="checkbox"/> Lightheadedness or swimming sensation | |

6. Check all that apply to other sensations you may have:

- | | |
|--|--|
| <input type="checkbox"/> Blacking out or fainting when dizzy | <input type="checkbox"/> Tingling around mouth |
| <input type="checkbox"/> Dizzy or unsteady constantly | <input type="checkbox"/> Spots before eyes |
| <input type="checkbox"/> Severe or recurrent headaches | <input type="checkbox"/> Jerking of arms or legs |
| <input type="checkbox"/> Double or blurry vision | <input type="checkbox"/> Dizzy when stand up quickly |
| <input type="checkbox"/> Numbness in the face or extremities | <input type="checkbox"/> Weakness/faintness after eating |
| <input type="checkbox"/> Weakness/clumsiness in arms, legs | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Slurred or difficult speech | |

7. Check all that apply to your hearing:

- | | | | |
|---|------------|---|------------|
| <input type="checkbox"/> Difficulty hearing | Right/Left | <input type="checkbox"/> Exposure to loud noise | Right/Left |
| <input type="checkbox"/> Ringing | Right/Left | <input type="checkbox"/> History of ear infection | Right/Left |
| <input type="checkbox"/> Fullness | Right/Left | <input type="checkbox"/> Change in hearing when dizzy | How? _____ |
| <input type="checkbox"/> Pain | Right/Left | <input type="checkbox"/> Previous ear surgery | Right/Left |
| <input type="checkbox"/> Discharge | Right/Left | When/what: _____ | |
| <input type="checkbox"/> Hearing changing | Right/Left | | |



8. Check all that apply to your medical history:

- | | |
|--|--|
| <input type="checkbox"/> Head injury | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Allergies: _____ | <input type="checkbox"/> Thyroid disease |
| _____ | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Migraine headaches |
| <input type="checkbox"/> Mental illness | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Seasickness or car sickness |
| <input type="checkbox"/> Back or neck injury | <input type="checkbox"/> Motion intolerance |
| <input type="checkbox"/> Back or neck pain | <input type="checkbox"/> Sensitivity to light and/or sound |

9. Check those that may be linked to your dizziness:

- | | |
|---|--|
| <input type="checkbox"/> Stress | <input type="checkbox"/> Recent change in eyeglasses |
| <input type="checkbox"/> Menstrual period | <input type="checkbox"/> Headaches |
| <input type="checkbox"/> Hormonal changes | <input type="checkbox"/> Loud noises |
| <input type="checkbox"/> Overwork or exertion | <input type="checkbox"/> Diet |

10. Check all that apply to your habits and lifestyles:

- Drink caffeine: How much? _____
- Drink alcohol: How much? _____
- Smoke/use tobacco: How much? _____

11. Please list any **current medical problems and length of illness:**

12. Please list all **surgeries and approximate dates:**

13. Please list **all medications** you currently take and their **dosages:**

14. Have you had any of the above medicines in the past 48 hours?

15. What tests have been done previously? (hearing test, MRI, CT, bloodwork, etc.)?

16. Do you have anything else to tell us about this problem that we haven't asked on this form?

Patient Signature

Date



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**I hereby sign this in acknowledgement that I have been presented
with a copy of Dr. Howard T. Mango's Notice of Privacy Practices.**

Name of Patient

Signature

Date