



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		Work Phone No. ()			
Employer's Address (Street/City/State/Zip)	Occupation	Email Address			
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. ()			
Primary Care Physician		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 Balance & Ear Institute, 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: List all medications that you are taking. Include over-the-counter drugs.

Name	Strength	Frequency

Have you had any of the above medications in the past 48 hours? Yes No
 Do you have any allergies to medications? Yes No I don't know. If known, please list below:

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

Year	Condition/Illness/Surgery	Length

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

- Do you smoke? No Yes _____ packs per day
- Do you drink alcohol? No Yes _____ glasses per day, week, month
- Do you drink caffeine products (tea, coffee, soda)? 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. Do 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 had have 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

meningitis
dry mouth
headaches
glaucoma
sneezing or runny nose
sinus trouble
dry eyes
eye disease or poor vision

Urinary

kidney disease
prostate problems
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
scarlet fever

Emotional

nervous breakdown
depression
chronic fatigue
suicidal tendencies
anxiety

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
arrhythmia
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?
 Please circle.
 Allergies Ear Pressure
 Cold Ear Drainage
 Dizziness 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. Do you have more difficulty understanding speech today than you did five years ago?
 Yes No 16. Do you have difficulty listening to music?
 17. How is your hearing? Please circle.
 Good Fair Poor

- Did you ever or do you now participate in (or use) any of the following? (answer each)
- Yes No 18. Motorcycling
 Yes No 19. Target shooting
 Yes No 20. Hunting
 Yes No 21. Snowmobiling
 Yes No 22. Auto racing
 Yes No 23. Power tools
 Yes No 24. Musical instruments
 Yes No 25. Private airplanes
 Yes No 26. Any job that is noisy
 Yes No 27. Farm equipment
 Yes No 28. Chainsaws
 Yes No 29. Were you in the military service or National Guard? What was your job? _____
 Yes No 30. Have you in your job or hobbies, been exposed to loud noise levels? (machinery, gunfire, rock music, etc.)
 Yes No 31. Do you wear hearing protection away from work? When started? _____
 Yes No 32. Were you working around loud noise during the last 14 hours?
 Yes No 33. Were you wearing hearing protection prior to this test today?
 Yes No 34. Do you have trouble understanding in crowds, in church or at meetings?
 Yes No 35. Do you have trouble understanding speech on the telephone?



Notice of Privacy Practices

To Our Patients

This notice describes how health information about you (as a patient of this practice) may be used and disclosed, and how you can get access to your health information. This is required by the Privacy regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our Commitment to Your Privacy

- Our practice is dedicated to maintaining the privacy of your health information.
- We are required by law to maintain the confidentiality of your health information.

We realize that these laws are complicated, but we must provide you with the following important information:

Use and Disclosure of Your Health Information in Certain Special Circumstances

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

Your Right Regarding Your Health Information

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact your home, rather than work. This may include contacting you by way of non-secured devices, such as answering machines, cellular phones, pagers, etc. We will accommodate reasonable requests.
2. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that we restrict our disclosure of your health information only to certain individuals in our care, such as family members and friends. If we do agree to your request, we are bound by agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.
3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Newport-Mesa Audiology Balance & Ear Institute, 500 Old Newport Blvd., Suite 101, Newport Beach, CA 92663, (949) 642.7935. You must provide us with a reason that supports your request for amendment.
4. Right to a copy of this notice. You are entitled to receive a copy of this notice of Privacy Practices. You may ask us to give you a copy of this Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.
5. Right to file a complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Newport-Mesa Audiology Balance & Ear Institute, 500 Old Newport Blvd., Suite 101, Newport Beach, CA 92663, (949) 642.7935.
6. Right to provide authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Newport-Mesa Audiology Balance & Ear Institute, 500 Old Newport Blvd., Suite 101, Newport Beach, CA 92663
Phone: (949) 642.7935 • Fax: (949) 642-2950 • www.dizziland.com



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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



Tinnitus Reaction Questionnaire (TRQ)

Name: _____ Date Completed: _____

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer all questions by circling the number that best reflects how your tinnitus has affected you over the past week.

		Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1.	My tinnitus has made me unhappy.	0	1	2	3	4
2.	My tinnitus has made me feel tense.	0	1	2	3	4
3.	My tinnitus has made me feel irritable.	0	1	2	3	4
4.	My tinnitus has made me feel angry.	0	1	2	3	4
5.	My tinnitus has led me to cry.	0	1	2	3	4
6.	My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7.	My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8.	My tinnitus has made me feel depressed.	0	1	2	3	4
9.	My tinnitus has made me feel annoyed.	0	1	2	3	4
10.	My tinnitus has made me feel confused.	0	1	2	3	4
11.	My tinnitus has "driven me crazy".	0	1	2	3	4
12.	My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13.	My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14.	My tinnitus has made it hard for me to relax.	0	1	2	3	4
15.	My tinnitus has made me feel distressed.	0	1	2	3	4
16.	My tinnitus has made me feel helpless.	0	1	2	3	4
17.	My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18.	My tinnitus has interfered with my ability to work.	0	1	2	3	4
19.	My tinnitus has led me to despair.	0	1	2	3	4
20.	My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21.	My tinnitus has led me to avoid social situations.	0	1	2	3	4
22.	My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23.	My tinnitus has interfered with my sleep.	0	1	2	3	4
24.	My tinnitus has led me to think about suicide.	0	1	2	3	4
25.	My tinnitus has made me feel panicky.	0	1	2	3	4
26.	My tinnitus has made me feel tormented.	0	1	2	3	4
Total						



Tinnitus History Questionnaire

Name: _____

DOB: _____ Date Completed: _____

Nature of the Tinnitus

How does the tinnitus sound? _____

Usual site of the tinnitus? (circle) Left=Right Left worse than Right Right worse than Left Central

Is the tinnitus constant or intermittent? _____

Does the tinnitus fluctuate in intensity or loudness? _____

What makes your tinnitus worse? _____

What makes your tinnitus better? _____

Tinnitus History

When did you first become aware of your tinnitus? _____

When did your tinnitus first become disturbing? _____

Under what circumstances did the tinnitus start? _____

What do you consider to have started the tinnitus? _____

Who have you consulted about your tinnitus? _____

What have previous professionals said your tinnitus is due to? _____

What treatments have you tried for your tinnitus?

None
TRT
Other - please comment _____

Hearing Aid
Counselling

Masker
Music Therapy

Tinnitus History Questionnaire

Name: _____

Date Completed: _____

Have you ever:

- Been exposed to gunfire or explosion?
How often were you exposed?
Did you wear hearing protection?
- Attended loud events? (e.g., concerts, clubs)
- Had any noisy jobs?
- Had any noisy hobbies or home activities?
- Had any head injuries or concussion?
- Had any operations involving your ear or head?
- Used solvents, thinners or alcohol based cleaners?
- Taken any of the following medications:
Quinine, Quinidine, Streptomycin, Kanamycin,
Dihydrostreptomycin, Neomycin

Y/N Details/Comments

Do you:

- Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?
- Regularly take aspirin or dispirin?
- Have any feelings of ear pressure or blockage?
- Do you find exposure to moderately loud sounds make your tinnitus worse?
- What is your current occupation?

Y/N Details/Comments

General Hearing Problems

- Do you have any difficulties hearing when there is background noise?
- Do you have difficulties understanding in one-to-one conversations?
- Do you have difficulties hearing the TV?
- Do you have difficulties hearing on the telephone?
- Do you have any dizziness or balance problems?
- Do you find external sounds unpleasant or uncomfortable?
- Do you dislike certain external sounds?
- Do you wear ear protection/ear plugs?

Y/N Details/Comments

Tinnitus History Questionnaire

Name: _____

Date Completed: _____

Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3).

	Hearing Loss
	Tinnitus
	Sensitivity to Loud Sounds

Effect of the Tinnitus

Y/N Details/Comments

Does your tinnitus prevent you from getting to sleep at night?

--	--

How many times per night did you awake in the last week? _____

How has tinnitus affected your work life? _____

How has tinnitus affected your home life? _____

How has tinnitus affected your social activities? _____

General Health

How has tinnitus affected your home life? _____

What is your general health like? _____

Are you taking any medications?

If yes, please specify. _____

Compensation

Y/N Details/Comments

Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claim or any other legal action in relation to your tinnitus?

--	--

Medical Contact Details _____

Name and Address of GP _____

Name and Address of ENT _____

I give consent to release results to my GP/ENT:

Signed

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?