NEWPORT-MESA AUDIOLOGY
BALANCE & EAR INSTITUTE

Newport Beach
500 Old Newport Boulevard
Suite 101
Newport Beach, CA 92663
949.642.7935 Phone
949.642.2950 Fax

Ladera Ranch
777 Corporate Drive
Suite 130
Ladera Ranch, CA 92694
949.642.7935 Phone
949.642.2950 Fax

dizziland.com

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 ☐ Single ☐ Married ☐ Divorced ☐ Widowed			
	Driver's License Number			
	Home Phone No. ( )			
Race (Please circle) American Indian/Asian/Pacific Islander/African American/White/Hispanic/Other	Ethnicity (Please circle) Hispanic/Other	Language (Please circle) English/Spanish/Indian/Other		
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/Relation	Relative's Phone No. ( )			
In Case of Emergency, Notify/Relation	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 ☐ Check ☐ Cash ☐ Visa ☐ MasterCard ☐ Insurance			
Billing Address(if different than above)				

Insurance Information

Primary Insurance Name	Phone No. ( )		Group No.
Name of Insured	Relationship	Date of Birth	ID No.
Secondary Insurance Name	Phone No. ( )		Group No.
Name of Insured	Relationship	Date of Birth	ID No.

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 anti-dizzy medications or sedatives 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 medical conditions.

_____

_____

D. Surgical History/Hospitalizations: List all surgeries. If applicable, list the year and the reason for any hospital admissions. Do not include normal pregnancies.

Year	Condition/Illness/Surgery	Length

E. Social History: 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, soda)? ☐ No ☐ Yes _____ cups per day, week, month

F. Family History:

1. Please write 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	kidney disease	tuberculosis
auto immune disease	hay fever	Menieres disease	vertigo
bleeding disorder	hearing loss	migraine	
cancer	heart disease	surgical complications	
dizziness	high blood pressure	stroke	

Relationship	Age	

G. 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

Hematology
bleeding disorder
anemia
previous transfusions

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

Genitourinary
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

Psychologic
nervous breakdown
depression
chronic fatigue
suicidal tendencies
anxiety

Skin
rashes
blistering of skin
eczema
psoriasis

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

H. 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?
When?
Yes No 5. Current symptoms include:
Please circle.

Allergies	Ear Pressure
Cold	Ear Drainage
Dizziness	Ear Infection
	Ear Pain

Yes No 6. Are you bothered by ringing noises?
Yes No 7. Are you now taking more than a few aspirins a day? Yes
No 8. Have you ever taken large doses of aspirin? Anacin, Bufferin, Emperin, or Quinine?
How many? _____ /day
Yes No 9. Have you ever taken medications known to be damaging to your ears?
Yes No 10. Have you ever received injections of any antibiotics of the mycin family? (gentamycin, kanamycin, vancomycin)
Yes No 11. Do you have ear drainage or pain?
Yes No 12. Have you ever suffered a severe head injury?
Yes No 13. Do you understand speech less than you did 5 years ago?
Yes No 14. Do you have difficulty listening to music?

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

Yes No 15. Motorcycling
Yes No 16. Target shooting
Yes No 17. Hunting
Yes No 18. Snowmobiling
Yes No 19. Auto racing
Yes No 20. Power tools
Yes No 21. Musical instruments
Yes No 22. Private airplanes
Yes No 23. Any job that is noisy
Yes No 24. Farm equipment
Yes No 25. Chainsaws
Yes No 26. Were you in the military service or National Guard? What was your job? _____
Yes No 27. Have you in your job or hobbies, been exposed to loud noise levels? (machinery, gunfire, rock music, etc.)
Yes No 28. Do you have trouble understanding in crowds, in church or at meetings?
Yes No 29. Do you have trouble understanding speech on the telephone?

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NOTICE OF PRIVACY PRACTICES

NEWPORT-MESA AUDIOLOGY BALANCE & EAR INSTITUTE, INC.

Gerry M. Miranda – Security Officer

Effective Date: September 23, 2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS IS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF: **THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPPA); THE HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH); THE GENETIC INFORMATION NONDISCRIMINATION ACT (GINA); ALSO KNOWN AS THE FINAL HIPPA OMNIBUS RULE.** PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it on a computer and in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Alternatively, we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or, we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities, which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation, which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure.

When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

22. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board or privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information, which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we cannot agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing.

We will charge a reasonable fee, which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Voice Phone (800) 368-1019
FAX (415) 437-8329
TDD (800) 537-7697
OCRMail@hhs.gov

The complaint form may be found at **www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf**. You will not be penalized in any way for filing a complaint.

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

-I authorize payment of medical benefits to:

Newport Mesa Audiology Balance and Ear Institute, Howard T. Mango, Au.D.,Ph.D.,
500 Old Newport Blvd, Suite 101, Newport Beach, CA 92663

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

-I understand that under 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.

-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

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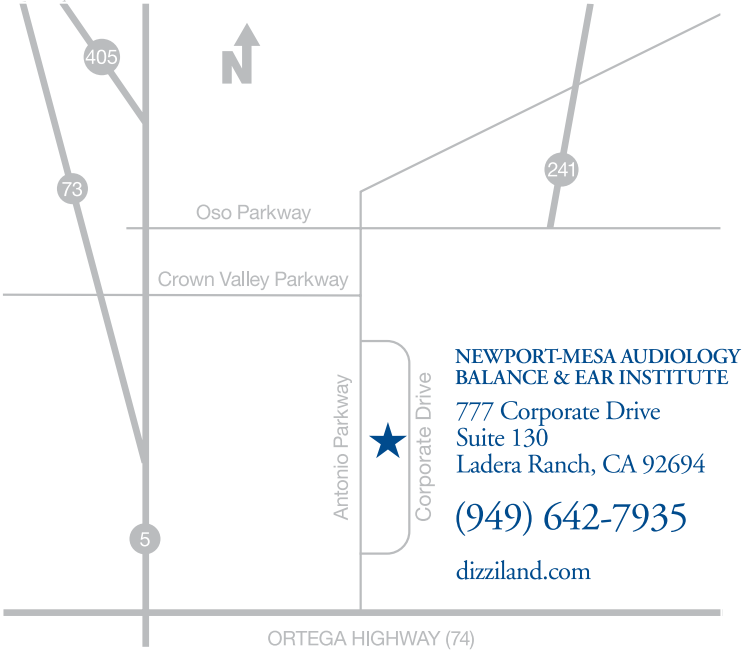
Dr. Howard T. Mango, Au.D., Ph.D.
Executive Director

Newport Beach

Ladera Ranch



Newport-Mesa Audiology Balance & Ear Institute

Appointment Location: ☐ Newport Beach ☐ Ladera Ranch

Appointment Date: _____ Time: _____ Arrival Time: _____

We will verify insurance prior to your appointment.

Please complete all forms prior to your appointment.

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Abbreviated Profile of Hearing Aid Benefit

Name: _____ Date: _____ File No.: _____

Instructions:

Please circle the answers that come closest to your everyday experience. Notice that each choice includes a percentage. You can use this to help you decide on your answer. For example, if the statement is true about 75% of the time, circle C for that item.

If you have not experienced the situation we described, try to think of a similar situation that you have been in and respond for that situation. If you have no idea, leave that item blank.

A	Always (99%)
B	Almost Always (87%)
C	Generally (75%)
D	Half-the-time (50%)
E	Occasionally (25%)
F	Seldom (12%)
G	Never (1%)

Example

		Without Hearing Aids							With Hearing Aids						
(a)	When I am in a meeting with several other people, *I can comprehend speech*.	A	B	C	D	E	F	G	A	B	C	D	E	F	G

		Without Hearing Aids							With Hearing Aids						
1.	When I am in a crowded grocery store, talking with the cashier, I can follow the conversation.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
2.	I miss a lot of information when I'm listening to a lecture.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
3.	Unexpected sounds, like a smoke detector or alarm bell are uncomfortable.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
4.	I have difficulty hearing a conversation when I'm with one of my family at home.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
5.	I have trouble understanding the dialogue in a movie or at the theater.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
6.	When I am listening to the news on the car radio, and family members are talking, I have trouble hearing the news.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
7.	When I'm at the dinner table with several people, and am trying to have a conversation with one person, understanding speech is difficult.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
8.	Traffic noises are too loud.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
9.	When I am talking with someone across a large empty room, I understand the words.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
10.	When I am in a small office, interviewing or answering questions, I have difficulty following the conversation.	A	B	C	D	E	F	G	A	B	C	D	E	F	G
11.	When I am in a theater watching a movie or play, and the people around me are whispering and rustling paper wrappers, I can still make out the dialogue.	A	B	C	D	E	F	G	A	B	C	D	E	F	G

A	Always (99%)
B	Almost Always (87%)
C	Generally (75%)

D	Half-the-time (50%)
E	Occasionally (25%)

F	Seldom (12%)
G	Never (1%)

		Without Hearing Aids	With Hearing Aids
12.	When I am having a quiet conversation with a friend, I have difficulty understanding.	A B C D E F G	A B C D E F G
13.	The sounds of running water, such as a toilet or shower, are uncomfortably loud.	A B C D E F G	A B C D E F G
14.	When a speaker is addressing a small group, and everyone is listening quietly, I have to strain to understand.	A B C D E F G	A B C D E F G
15.	When I'm in a quiet conversation with my doctor in an examination room, it is hard to follow the conversation.	A B C D E F G	A B C D E F G
16.	I can understand conversations even when several people are talking.	A B C D E F G	A B C D E F G
17.	The sounds of construction work are uncomfortably loud.	A B C D E F G	A B C D E F G
18.	It's hard for me to understand what is being said at lectures or church services.	A B C D E F G	A B C D E F G
19.	I can communicate with others when we are in a crowd.	A B C D E F G	A B C D E F G
20.	The sound of a fire engine siren close by is so loud that I need to cover my ears.	A B C D E F G	A B C D E F G
21.	I can follow the words of a sermon when listening to a religious service.	A B C D E F G	A B C D E F G
22.	The sound of screeching tires is uncomfortably loud.	A B C D E F G	A B C D E F G
23.	I have to ask people to repeat themselves in one-on-one conversation in a quiet room.	A B C D E F G	A B C D E F G
24.	I have trouble understanding others when an air conditioner or fan is on.	A B C D E F G	A B C D E F G

Please fill out these additional items.

Hearing Aid Experience	**Daily Hearing Aid Use**	**Degree of Hearing Difficulty** *(without a hearing aid)*
☐ None	☐ None	☐ None
☐ Less than 6 weeks	☐ Less than 1 hour per day	☐ Mild
☐ 6 weeks to 11 months	☐ 1 to 4 hours per day	☐ Moderate
☐ 1 to 10 years	☐ 4 to 8 hours per day	☐ Moderately-severe
☐ Over 10 years	☐ 8 to 16 hours per day	☐ Severe