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AUDIOLOGY CLINIC
OF NORTHERN ALBERTA
ACNA

PATIENT INFORMATION SHEET

Date _____
Month Day/ Year

Name Title (circle one): Dr. Mrs. Ms. Mr. _____ *other*

First _____ Initial _____ Last _____

Address Street _____

City _____ Province _____ Postal Code _____

Contact information
(please circle your main number or your main alternate contact)

- Home Phone _____
- Work Phone _____ extension _____
- Cell Phone _____
- Email _____

- Alternate Contact 1 _____ Address _____
  Relationship _____ Phone 1 _____ Phone 2 _____
- Alternate Contact 2 _____ Address _____
  Relationship _____ Phone 1 _____ Phone 2 _____

Other information

Date of Birth _____
Month Day/ Year

Health Care Number _____

Social Insurance Number _____
Optional

Spouse's name _____

Family Physician _____

Referral information

How did you hear about us?

_____

_____

_____

If from another patient, who referred you?

_____

Third Party Information

I am covered by (circle one): DVA WCB AB WCB ... _____ NIHB _____ AADL AISH
other province *other*

Claim / Identification Number _____

Release of Information

I, _____, understand that Audiology Clinic of Northern Alberta will only use personal information that I provide, to serve me with the services that I request. Audiology Clinic of Northern Alberta may share my personal information only with organizations that participate in my care including but not limited to my physician, the manufacturer of my products, and any third party participating in the payment of my products and/or services.

I also understand that Audiology Clinic of Northern Alberta abides by Alberta's privacy laws and regulations and has a privacy policy that I can request and/or view online.

I therefore give consent to Audiology Clinic of Northern Alberta to responsibly use my personal information to contact me and share with others only as required to serve my needs.

Signed this _____ day of _____, 20____ in Edmonton, Alberta:

_____
Signed Name

_____
Printed Name

Audiology Clinic of Northern Alberta

7807 109 Street, Edmonton, Alberta, T6G 1C6
Phone: (780) 433-4441 Email: info@acnahearing.com

HEARING HANDICAP INVENTORY FOR ADULTS – SCREENER

INSTRUCTIONS: The purpose of this questionnaire is to identify the problems your hearing loss may (or may not) be causing you. Circle Yes, Sometimes or No for each question. Please do not skip a question if you avoid a situation because of a hearing problem**.**

E-1	Does your hearing problem cause you to feel embarrassed when meeting new people?	Yes	Sometimes	No
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family?	Yes	Sometimes	No
S-1	Does a hearing problem cause you difficulty hearing/understanding co-workers, clients or customers?	Yes	Sometimes	No
E-3	Do you feel handicapped by a hearing problem?	Yes	Sometimes	No
S-2	Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?	Yes	Sometimes	No
S-3	Does a hearing problem cause you difficulty in the movies or theater?	Yes	Sometimes	No
E-4	Does a hearing problem cause you to have arguments with family members?	Yes	Sometimes	No
S-4	Does a hearing problem cause you difficulty when listening to the TV or radio?	Yes	Sometimes	No
E-5	Do you feel that any difficulty with your hearing limits or hampers your personal or social life?	Yes	Sometimes	No
S-5	Does a hearing problem cause you difficulty when a restaurant with relatives or friends?	Yes	Sometimes	No

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CASE HISTORY

Patient _____ Date _____

1 Why are you getting a hearing test?

2 Have you had your hearing tested before? ☐ Yes ☐ No
Details if 'Yes':

3 Do you have a hearing loss? ☐ Yes ☐ No
Details if 'Yes':

4 Does anyone in your family have a hearing loss? ☐ Yes ☐ No
Details if 'Yes':

5 Have you ever had an ear surgery? ☐ Yes ☐ No
Details if 'Yes':

6 Have you seen a physician recently? ☐ Yes ☐ No
Details if 'Yes':

7 Do you have a history of ear infections? ☐ Yes ☐ No
Details if 'Yes':

8 Do you suffer from:

☐ High Blood Pressure	☐ Diabetes	☐ Renal Difficulties
☐ Stroke	☐ Circulatory Problems	☐ STD
☐ Cognitive Difficulties	☐ Vision Problems	☐ Cancer
☐ Dexterity Problems	☐ Arthritis	

9 What medications do you take?

10 Do you have a history of noise exposure? ☐ Yes ☐ No
Details if 'Yes':

11 Do you have tinnitus? ☐ Yes ☐ No
Details if 'Yes':

12 Do you suffer from:

☐ Dizziness	☐ Loss of Balance	☐ Light Headedness
☐ Room Spinning		

13 Have you ever had a head injury? ☐ Yes ☐ No
Details if 'Yes':

14 Do you currently wear hearing aids?

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