

Patient Name: _____ DOB: _____ Date of Visit: _____

HEARING SCREENING:

Yes No

1. Do you have a problem hearing over the telephone?		
2. Do you have trouble following the conversation when two or more people are talking at the same time?		
3. Do people complain that you turn the TV volume up too high?		
4. Do you have to strain to understand conversation?		
5. Do you have trouble hearing in a noisy background?		
6. Do you find yourself asking people to repeat themselves?		
7. Do many people you talk to seem to mumble (or not speak clearly)?		
8. Do you misunderstand what others are saying and respond inappropriately?		
9. Do you have trouble understanding the speech of women and children?		
10. Do people get annoyed because you misunderstand what they say?		
TOTAL "Yes" responses (2 or more indicates the need for a referral)		

BALANCE/FALL SCREENING

Yes Sometimes No

Do you feel depressed about your dizziness/imbalance?			
Does walking down a sidewalk increase your dizziness/imbalance?			
Is it difficult to concentrate due to dizziness?			
Is it difficult for you to walk around your house in the dark due to dizziness?			
Does bending over increase your dizziness/imbalance?			
Do you restrict travel for business/recreation due to your dizziness/imbalance?			
Does your dizziness/imbalance interfere with job/household responsibilities?			
Are you afraid to leave the house alone due to dizziness/imbalance problems?			
Have you ever been embarrassed around others due to dizziness/imbalance?			
Does your dizziness/imbalance cause significant social restrictions?			
Have you fallen in the past year?			
Totals: "Yes" = 4 pts., "Sometimes" = 2 pts., "No" = 0 pts., Abnormal =2-4 pts.			

DEPRESSION SCREEN

Yes No

Over the past two weeks, have you felt down, depressed or hopeless?		
Over the past two weeks have you felt little interest or pleasure in doing things?		

Have you had any of the following symptoms in the past four months?

- | | | |
|---|--|--|
| <input type="checkbox"/> Weight Loss/gain | <input type="checkbox"/> Cough | <input type="checkbox"/> Yellow eyes/skin |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Frequent urination |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Difficulty urinating/incontinent |
| <input type="checkbox"/> Loss of consciousness | <input type="checkbox"/> Backache | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Joint swelling or pain | <input type="checkbox"/> Excessive tiredness |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Chest pain/pressure/heaviness | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Change in eyesight | <input type="checkbox"/> Stomach/abdominal pain | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Depression/tearfulness |
| <input type="checkbox"/> Ears ringing/hearing loss | <input type="checkbox"/> Nausea vomiting | <input type="checkbox"/> Hot flashes |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Hair loss |
| <input type="checkbox"/> Swelling of the ankles | <input type="checkbox"/> Constipation | <input type="checkbox"/> Extra heart beats or racing heart |
| <input type="checkbox"/> Black or bloody bowel movements | <input type="checkbox"/> Heartburn/indigestion | <input type="checkbox"/> Unusual bruising or bleeding |
| <input type="checkbox"/> Changes in wart/mole/skin growth | <input type="checkbox"/> Difficulty swallowing/food sticking | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Nasal congestion/drainage | <input type="checkbox"/> Loss of strength or speech | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Other _____ | <input type="checkbox"/> face pain | <input type="checkbox"/> Leg cramps |

Provider Signature: _____ Date: _____