LEGACY HEALTH | GOOD SAMARITAN MEDICAL CENTER

Registration Form

Name:_____ **Date of Birth:** _____
Last First Middle Initial

Home/Mailing Address:_____
Street City State Zip Code

Home Phone: _____ **Cell Phone:**_____

Email Address:_____

Primary Care Provider:_____

Race:_____

Country of Origin:_____

Religious Preference (if any):_____

Employment Status:

- ☐ Full-Time Employed
- ☐ Part-Time Employed
- ☐ Self-Employed
- ☐ Retired
- ☐ Student
- ☐ Not Employed

Marital Status:

- ☐ Married
- ☐ Single
- ☐ Widowed
- ☐ Separated
- ☐ Divorced
- ☐ Significant Other
- ☐ Domestic Partner
- ☐ Other

Emergency Contact:

Name:_____**Relationship:**_____ **Phone:** _____

Legacy Good Samaritan Hospital
Audiology and Vestibular Lab
1040 N.W. 22nd Ave., # 460
Portland, OR 97210
503-413-8154

Name: _____

Hearing History:

Yes No

☐ ☐ Do your friends or family suspect that you have a hearing loss?
☐ ☐ Do you think that you have a hearing loss? ☐both ears ☐right ear ☐left ear
If so, when did you first become aware of it? _____
Has your hearing loss come on gradually over time or was it sudden? _____
If you have hearing loss, is your hearing loss stable or does it change? _____
☐ ☐ Do you know the cause of your hearing loss? If so, please explain: _____
_____

☐ ☐ Do you have problems hearing well when talking with someone on the telephone?
☐ ☐ Are you able to hear the smoke detector whether you wear hearing aids or not?
☐ ☐ Do you have a history of loud noise exposure? (Firearms, loud machinery, etc.)
☐ ☐ Do you have ringing or other sounds (tinnitus) in your ears? ☐both ears ☐right ear ☐left ear
If so, would you describe it as ☐mild ☐moderate ☐severe?
☐ ☐ Do you have a pressure or plugged up feeling in the ears? ☐both ears ☐right ear ☐left ear
☐ ☐ Do you have ear pain? ☐both ears ☐right ear ☐left ear

☐ ☐ Did you have frequent ear infections as a child?
☐ ☐ Have you had ear infections as an adult?
☐ ☐ Is there a history of hearing loss in your family? _____
☐ ☐ Have you had wetness or drainage from one or both ears?
☐ ☐ Have you ever had ear surgery? ☐both ears ☐right ☐left
If so, what type of ear surgery? _____
☐ ☐ Do you have an <u>unusual</u> ability to hear body sounds (e.g. “I can hear my eyes move.”)

Other health problems:

Yes No

☐ ☐ Have you ever suffered a serious head trauma or a brain injury?
☐ ☐ Have you ever had a brain tumor, aneurysm, and/or had brain surgery?
☐ ☐ Have you ever had a stroke?
☐ ☐ Have you ever had shingles?
☐ ☐ Have you ever had meningitis or encephalitis?
☐ ☐ Have you ever had a temporary paralysis of one side of your face (Bell’s Palsy)?
Which side of your face was affected? ☐ right ☐ left ☐ cannot recall
☐ ☐ Do you have diabetes?
☐ ☐ Have you ever been given high doses of antibiotics for a severe infection or quinine for malaria?
☐ ☐ Have you ever received chemotherapy or radiation treatments?
If so, please explain: _____
☐ ☐ Do you have jaw problems such as pain, clicking, popping or your jaw getting stuck open or closed?
☐ ☐ Have you ever had migraine headaches?
☐ ☐ Were you born with a gray or white patch of hair or develop one by early adulthood or did your hair gray unusually early?

If you are having problems with dizziness or imbalance, please check (☑) all symptoms that apply to you:

☐ A loss of balance. If so, when did this first begin?_____
☐ Loss of balance with falls. If so, how many times have you fallen in the past two years?_____

☐ A true spinning or whirling vertigo. If so, when did this first begin?_____
How long does it typically last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days
How often do you have the spinning vertigo? _____
Do you know what triggers it? (lying down, tilting your head backward or rolling over in bed)
_____

☐ Dizziness (other than a spinning or whirling sensation). If so, when did this first begin?_____
How long does it typically last? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days
How often do you feel dizzy? _____

How would you best describe your dizziness?

- ☐ A rocking sensation as if I were on a ship or boat
- ☐ A sudden earthquake-like sensation as if the floor moved or I were suddenly shoved
- ☐ Lightheadedness
- ☐ A feeling I am about to faint.
- ☐ Dizziness or visual changes when I hear a loud noise
- ☐ Other:_____

Is there any other information that you feel would be useful for us to know prior to your testing?

_____
_____
_____

Please print or attach a list of all the medications, supplements and over-the-counter products you take and the reason you take it. Please include the dosage (25mg, 250mg) and the "route" (how you take them such as: tablet, capsule, injection, ointment, nasal spray, etc.).

Medication/Supplement/Product	Dosage	Route	Reason you take it

Thank you!

(03/01/2022)