MANATEE HEARING & BALANCE CENTER

CELEBRATING OVER 50 YEARS

HEALTH QUESTIONNAIRE

1) Do we have a copy of your current list of medications? ☐ Yes ☐ No **If NO**, please provide this to our front staff before the end of your visit today.

2) Do you **CURRENTLY** experience ringing in your ears? ☐ Yes ☐ No **If YES**, please fill out Section 2b below. **If NO,** please skip to question 3.

2b) **Duke Anxiety-Depression Scale (DUKE-AD)**

PART 1 — SCORING: 2 = Yes, describes me exactly 1= Somewhat describes me 0 = No, doesn't describe me at all

I give up easily	☐ 2	☐ 1	☐ 0
I have difficulty concentrating	☐ 2	☐ 1	☐ 0
I'm uncomfortable around people	☐ 2	☐ 1	☐ 0

PART 2 — SCORING: 2 = A lot 1= Some 0 = None

During the PAST WEEK, how much trouble have you had with:

Sleeping	☐ 2	☐ 1	☐ 0
Getting tired easily	☐ 2	☐ 1	☐ 0
Feeling depressed or sad	☐ 2	☐ 1	☐ 0
Nervousness	☐ 2	☐ 1	☐ 0

Add up your total score

☐

3) How many falls have you had in the past year?

A fall is defined as a "sudden, unintentional change in position causing an individual to land at a lower level, on an object, the floor, or the ground, other than as a consequence of sudden onset of paralysis, epileptic seizure, or overwhelming external force."

☐ A) None ☐ B) One fall without injury ☐ C) One fall with medical injury ☐ D) More than one fall (with or without injury)

*** **If answer is C or D**, please see Fall Risk Assessment documentation given by the Audiologist.***

4) Do you currently use tobacco? ☐ Yes ☐ No

*** **If YES**, please obtain pamphlet regarding health risks at the front desk for your information. ***

Print Name_____ DOB_____

Patient Signature_____ Date_____

Audiologist Signature_____ Date_____