Please note, we are unable to give you a copy of your results per our contract with the third party you were referred by and the VA. You may request a copy from the VA after your claim has been adjudicated, typically in 6-8 weeks.

COASTAL AUDIOLOGY AND HEARING AID CENTER

OFFICE USE ONLY:

TriWest_____ QTC_____

VES_XXX_ LHI_____

OTHER_____

Audiology VA Case History

Today's date: _____ Patient name: _____ DOB_____

What is your primary complaint today regarding your ears and/or hearing?_____

_____

What are your approximate dates of service?_____to_____ Primary job in the service_____

How would you best describe your hearing? _____ My hearing is fine with no concerns

_____ Trouble hearing in noisy environments _____Trouble hearing in group situations

_____Able to hear but not clearly _____Trouble hearing from a distance _____Unable to hear

Which ear is your better ear? *(check one)* _____ Same in Both Ears _____ Right _____ Left

Please ***describe*** how the hearing loss affects your daily life, including your ability to work:_____

_____

Do you notice any noises in your ears you would describe as ringing, roaring or buzzing, called tinnitus?

Yes____ No_____ If Yes, *When did it start or when did you first notice it?*

_____

_____

Please ***describe*** the circumstances of how it began:_____

_____

Is it constant or does it come and go?_____

What does it sound like?_____

Has it gotten worse since it began or has it stayed the same?_____

If it has worsened, please describe how_____

Please ***describe*** how the tinnitus affects your daily life, including your ability to work: _____

_____

Please ***describe*** your history of noise exposure in the three following areas: ***PLEASE DO NOT PUT, "YES/NO". DESCRIBE THE TYPE OF NOISE YOU WERE EXPOSED TO AND HOW OFTEN.***

Noise exposure prior to military service:

Military noise exposure: ***(DESCRIBE)***

Noise exposure after military service:

When firing weapons, which hand do you USUALLY fire with? _____Right _____Left

Medical information:

Have you had earaches or drainage from your ears **in the past 90 days**? Yes____ No____

Have you ever had medical or surgical treatment for your ears? Yes____ No____

If yes, please explain:_____

Have you ever had any of the following?

Diabetes____ Injury to the head____ Seizures____ Allergies____ High blood pressure_____

Tuberculosis____ Scarlet fever_____

Does anyone in your family have hearing loss? Yes____ No___

Signature_____ Date_____

Veterans Evaluation Services

ph: 877.637.8387/ web: vesservices.com

Veterans Evaluation Services COVID-19 Screening Questions

If you are attending an in-person exam, please ensure you complete this form the day of your appointment. Please provide a copy upon check-in.

1. Have you or anyone in your household had any of the following symptoms in the last 14 days
   - Sore throat
   - Cough
   - Chills
   - Body aches for unknown reasons
   - Shortness of breath for unknown reasons
   - Loss of smell / loss of taste
   - Fever at or greater than 100 degrees Fahrenheit

   YES ☐ NO ☐
2. Are you currently experiencing any of the above symptoms? YES ☐ NO ☐
3. Have you or anyone in your household tested positive for COVID-19? YES ☐ NO ☐
   a. If yes, how long ago?
   b. If yes, is there any additional information you'd like to add?
4. Have you or anyone in your household cared for an individual who is in quarantine, is a presumptive positive, or has tested positive for COVID-19 within the last 14 days? YES ☐ NO ☐
5. Do you have any reason to believe you or anyone in your household has been exposed to or acquired COVID-19 within the last 14 days? YES ☐ NO ☐
6. To the best of your knowledge have you been in close proximity to any individual who tested positive for COVID-19 within the last 14 days? YES ☐ NO ☐
7. Personal protective equipment is required for your examination. Are you willing to wear PPE for the duration of your evaluation? YES ☐ NO ☐

Veteran Name: _____

VES #: _____ (To be completed by Clinic Staff)

Temperature Reading: _____ (To be completed by Clinic Staff)

Notice of Privacy Practices

This practice is determined to protect the privacy of your medical information. As we provide service to you, we create and store health information (a medical record) that identifies you. It is often necessary to share or disclose this health information in order to provide treatment for you, obtain payment and to conduct healthcare operations in our office.

This Notice of Privacy Practices requires us to:

1. Keep your medical records private and to provide you with this notice.
2. Change our privacy practices and the terms of this notice at any time, ensuring our notice is effective, even for information recently obtained.
3. Before we make an important change in our privacy practices, we would change this notice and make the new notice available upon request.

You have individual rights as part of the notice of Privacy Practices. As a patient of Coastal Audiology and Hearing Aid Center, you have the right to:

1. Photocopies of your medical records on file and/or a copy of this Notice of Privacy Practices. If you need a photocopy, please notify the receptionist.
2. Receive a list of all the times your medical information has been shared by our office or our business associates, other than treatment, payment, healthcare operations and/or other specified exceptions.
3. Request we communicate with you about your medical information by different means or to different locations. This request must be made in writing to Coastal Audiology & Hearing Aid Center.
4. Request a change to your health information if you think it is incomplete or inaccurate. However, if the audiologist, hearing healthcare professional or office personnel believe the patient's health information is complete and accurate, he/she can refuse to make the requested changes. This request must be made in writing to Coastal Audiology & Hearing Aid Center.
5. Request a paper copy if you have received this Notice of Privacy Practices electronically. This request must be made in writing to Coastal Audiology & Hearing Aid Center

The following is a description of the different circumstances that may require this practice to use or disclose your medical information:

1. Share medical data with another provider who is responsible for your care (physicians, audiologists, nurses, any other healthcare professionals, technicians, students in healthcare, or any other people who take care of you), make referrals and/or placing lab/prescription orders.
2. Share your health insurance plan information about a treatment you received at our practice when filing a claim for reimbursement or determination of benefits.
3. Disclose your medical information for our healthcare operations.
4. Share information about your condition(s), location and/or death to family member(s), or your personal representative(s). Prior permission by you will be obtained unless in case of emergency. If we are unable to obtain permission, we will share only the health information directly necessary for your healthcare.
5. Disclose medical information to a medical examiner to identify a deceased person or to determine the cause of death, or for tissue donations.
6. Medical information may be disclosed if you are military personnel, either active or a veteran, and if required by the appropriate authorities.
7. Share medical data to the public health and/or law enforcement official whose job is to prevent or control disease, injury or disability.
8. Share medical data to a representative from the Food and Drug Administration for the purpose of reporting adverse effects stemming from defective products, etc.
9. Medical information may be disclosed when necessary to comply with Workers' Compensation.
10. Medical information may be disclosed when in response to a court and/or administrative order in a lawsuit or similar proceeding.

Please sign below indicating you understand our Privacy Policy.

Patient Signature_____ **Date**_____

Have you avoided excessive or hazardous noise exposure for at least 14 hours? _____
(ex: aircraft, loud machines, concerts, lawn equipment, etc.) ***You need to be excessive-noise free for at least 14 hours or you will need to reschedule your exam.***

If not, how long has it been since you were exposed to excessive/hazardous noise? _____