Referral:_____

# Patient Information

Date:_____

Name:_____DOB:_____ Age:_____

Address: _____City/State/Zip_____

Home Phone: _____Cell Phone:_____

Work Phone: _____ Email address: _____

Occupation: _____ Contact Person: _____

Phone #_____ Primary Care Doctor: _____

Address_____ Phone # _____

Primary Insurance/ID# _____Secondary Insurance/ ID # _____

## PLEASE HAVE A MEDICATION LIST

| | | |
|---|---|---|
| Do you think/know you have a hearing loss? | YES / NO | |
| Have you ever had your hearing tested? | YES / NO | When?_____ |
| Do you have tinnitus/ringing in your ears? | YES / NO | |
| Are you a veteran? | YES / NO | |
| ANY surgery/trauma to head or neck? | YES / NO | Describe _____ |
| Has he/she been exposed to loud noises? | YES / NO | Describe _____ |
| Do you experience any acute/chronic dizziness? | YES / NO | |
| Family history of hearing loss? | YES / NO | |
| Do you or have you ever worn hearing aids? | YES / NO | |
| Do you take any aspirin or blood thinners? | YES / NO | |

## PLEASE CHECK ALL THAT APPLY

| | | |
|---|---|---|
| _____Stroke | _____Arthritis | _____Shingles |
| _____Memory loss | _____Ear infections | _____ Radiation |
| _____Neuropathy | _____Vision Problems | _____Cancer |
| _____Depression/Anxiety | _____High blood pressure | _____Chemotherapy |
| _____Head Injury | _____Diabetes Type (1)__ or (2)__ | _____ Heart condition |
| _____Epilepsy/ Seizures | _____Migraine | _____Tobacco Use |

Please list any medical conditions or history I should be aware of: _____

# ELDER ABUSE SUSPICION INDEX © (EASI)

| EASI Questions<br>Q 1-Q 5 asked of patient; Q 6 answered by doctor<br>*(Within the last 12 months)* | | | |
|---|---|---|---|
| 1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals? | YES | NO | Did not answer |
| 2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with? | YES | NO | Did not answer |
| 3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened? | YES | NO | Did not answer |
| 4) Has anyone tried to force you to sign papers or to use your money against your will? | YES | NO | Did not answer |
| 5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically? | YES | NO | Did not answer |
| 6) **Doctor:** Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months? | YES | NO | Not sure |



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