

Cadence Hearing Services, LLC

Name:

Date of birth:

Date of visit:

What is the nature of your visit? :

How long has this occurred?

Please indicate if you have or are experiencing the following:

- Ear pain
- Ear drainage
- Depression
- Hearing loss
- Tinnitus (Ringing/Buzzing in ears)
- Dizziness
- Anxiety
- Trauma to the ear/head
- Ear fullness
- Occupational noise exposure
- Social noise exposure
- Ear surgery
- Ear wax problem

Prior medical history

Please indicate if you have a family history of hearing loss, tinnitus, vertigo.

Have you ever been treated by another professional for the above?

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Office use only:

Tests today:

Reason for the tests:

Otoscopically:

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Hearing aid evaluation:

Take ear impressions:

Lynda Wayne, Au.D- Audiologist