

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 your child is 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
- School issues/Reading/Math
- Past ear infections/tubes
- Problems at birth, high bilirubin, low birth weight, any milestone delays
- Not hearing parents/caregivers
- Concerns for language and or speech development

Prior medical history

Please indicate if there is a family history of hearing loss, tinnitus, vertigo.

List any other issues your child may be having or has had since birth:

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

Office use only:

Tests today:

Reason for the tests:

Otoscopically:

Lynda Wayne, Au.D
