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
