Name _____

What is the primary reason for your visit today?
____Hearing Issues____ Dizziness/Vertigo ____ Tinnitus Other _____

Do you have ringing orbuzzing in your ears? ____ Yes____ No Which ear? Left Right

How long have you experienced the issues above?
___Less than 1 yr___1-5yrs___5+yrs

Have you ever had a hearing test?___Yes ___No
Ifso, by whom and when? _____

Was your hearing loss sudden or gradual onset and in which ear?
___ Sudden___ Gradual ___Left Ear ___Right Ear ___Same in Both Ears

Have you experienced any of thefollowing in the last 90 days?
___Excessive Ear Wax ___Ear Drainage/Bleeding___Ear Pressure/Fullness___Swimmer's Ear
___Dizziness/Vertigo ___Ear Pain ___Fluctuating Hearing Loss ___Popping Sensation in Ear

Have you had any medical/surgical treatment to your ears? Describe_____
_____
_____

Have you been diagnosed with any ofthefollowing?
___Cholesteatoma___Otosclerosis___Sudden Hearing Loss ___Acoustic Neuroma
___Ossicular Dislocation___Meniere's Disease

Have you been exposed to any of the following?
___ Power Tools ___ Hunting/Firearms ___Loud Music ___ Occupational/IndustrialNoise

Have you had or do you currently have any ofthe following conditions?
___ Cardiovascular Disease ___ Head Injury ___ Illness with High Fever___ Vision Problems
___ High Blood Pressure___Dizziness___ Dementia/Alzheimer's___Multiple Sclerosis
___ Pacemaker___ Balance Concerns___ Cognitive Issues___ Parkinson's Disease
___ Stroke___ Diabetes ___Seizures___ Cancer ___ Arthritis