CARDINAL
HEARING CENTERS

History Questionnaire

Complete Hearing Evaluations

Cochlear Implant Evaluations & Management

Tinnitus Evaluations & Management

Tympanograms, OAE, & Reflex Testing

Digital Hearing Devices

Repair of Hearing Aids

Assistive Listening Devices

Noise, Swim, and Musician Protection

Audiologic Worksite Assessments

Hearing Loss Education Services

Balance/VNG Evaluations

Patient Name: _____ DOB:_____Date: _____

Primary and/or Referring Physician: _____

Please, briefly describe the reason for today's visit, in your own words. _____

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_____

Have you noticed any hearing loss? ☐Yes ☐No

☐Stable ☐Progressive (getting worse) ☐Fluctuating

Have you experienced any ringing in the ears? ☐Yes ☐No (☐Left ☐Right ☐Both)

Have you experienced a sensation of fullness in your ears? ☐Yes ☐No (☐Left ☐Right ☐Both)

Have you experienced any pain in your ears? ☐Yes ☐No (☐Left ☐Right ☐Both)

Have you noticed any drainage from either ear? ☐Yes ☐No (☐Left ☐Right ☐Both)

Do you have a history of ear surgery? ☐Yes ☐No (☐Left ☐Right ☐Both)

Have you experienced any dizziness? ☐Yes ☐No

Have you experienced any spinning sensations? ☐Yes ☐No

Do you fall frequently? ☐Yes ☐No

Do you smoke? ☐Yes ☐No

Do you have any concerns of depression? ☐Yes ☐No

Do you have any other health problems, and/or take any medications? ☐Yes ☐No

Please list anything else you feel that we should know, along with any health conditions and/or medications.

Thank you!

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