EAR·NOSE·THROAT SPECIALISTS
of Northern Virginia, P.C.

PROFESSIONAL HEARING SERVICES
The Dizziness and Balance Center
The Hearing Aid Center

ADULT QUESTIONNAIRE

Name: ______________________ Date of evaluation: ______________

DOB: ______________________ Referring physician: ______________

Reason for the appointment: ______________________________

How did you hear about us? ______________________________

Please check the appropriate "Yes" or "No" box that applies to you:

Yes	No	
☐	☐	Difficulty hearing
☐	☐	Sudden hearing loss
☐	☐	Family history of hearing loss
☐	☐	Tinnitus (ex. ringing or roaring in the ears)
☐	☐	Prolonged periods of noise exposure
☐	☐	Ear surgeries
☐	☐	Ear infections
☐	☐	Ear drainage
☐	☐	Malformation of the ear(s)
☐	☐	Wax build up in the ear(s)
☐	☐	Ear pressure/fullness
☐	☐	Spinning vertigo
☐	☐	Lightheaded/off balance
☐	☐	Blurred vision
☐	☐	Interested in hearing aids

Please note any other relevant medical history:

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Please list medications:

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