



**ADULT AUDIOLOGY INFORMATION PACKET  
DIAGNOSTIC EVALUATION**

***Cover letter***

***Driving Directions to CSHC***

***Diagnostic Vestibular Testing***

***Balance Testing Preparation***

***Dizzy Questionnaire***

***If you intend to seek insurance reimbursement***

***Patient Intake & Insurance Information***

***Case History Form***

***Consent to Treat***

**FOR MEDICARE PATIENTS ONLY:**

***Medicare regulations governing outpatient rehabilitation services***

***Determining if Medicare is the primary payor***

***In order to be able to properly complete, save and resend, please adhere to the following steps:***

***1. Download and save to your computer 1<sup>st</sup>***

***2. Reopen the document and complete form***

***3. Save and then attach in an email to Chris Weik***

***cweik@cshcga.com.***

***4. \*Print your name in signature blocks. Upon arrival at CSHC you will be asked to sign where needed.***

***\*In order to have a diagnostic appointment schedule, please either: 1) complete and email these forms to Chris Weik @ cweik@cshcga.com, 2) hand deliver to our office, or 3) mail them back via USPS.***

***Upon receipt, and review, someone from our office will contact you to schedule an appointment.***

***Thanks in advance for completing these forms, we look forward to seeing you in our office.***



# Columbus Speech & Hearing Center

2424 Double Churches Road  
Columbus, Georgia 31909  
(706) 324-6112 / (706) 596-8259 fax

To whom it may concern:

Your physician has referred you to Columbus Speech & Hearing Center for a hearing evaluation and/or balance evaluation.

In order to proceed with scheduling an appointment, please complete the enclosed documents and return them to us as soon as possible. When we receive the completed documents, we will contact you to schedule the evaluation appointment.

Please tell us the best way to contact you (check all that apply):

- Phone – give us the number to call \_\_\_\_\_
- Text – give us the number to text \_\_\_\_\_
- EMAIL – give us your email address \_\_\_\_\_
- Please tell us when it is best to contact you \_\_\_\_\_

- Text – **Opt in for TEXT reminders to avoid no-show and late fees. TEXT CSHC to 622622**

I have opted in for TEXT reminders to be sent to this cell number \_\_\_\_\_

I do not want TEXT reminders

If you have questions about scheduling, contact Dawn Fernandez at 706-324-6112, extension 204. Feel free to leave Dawn a voice message if she is not available.

Please note that once the evaluation appointment is scheduled this time is dedicated just for you. If you need to cancel or change the appointment, please contact us 48 hours prior to the appointment to avoid a \$50.00 rescheduling fee.

We look forward to seeing you soon.

Chris Weik  
Front Office Supervisor  
[cweik@cschcga.com](mailto:cweik@cschcga.com) 706-324-6112 extension 230

*Enclosed forms for your general information:*

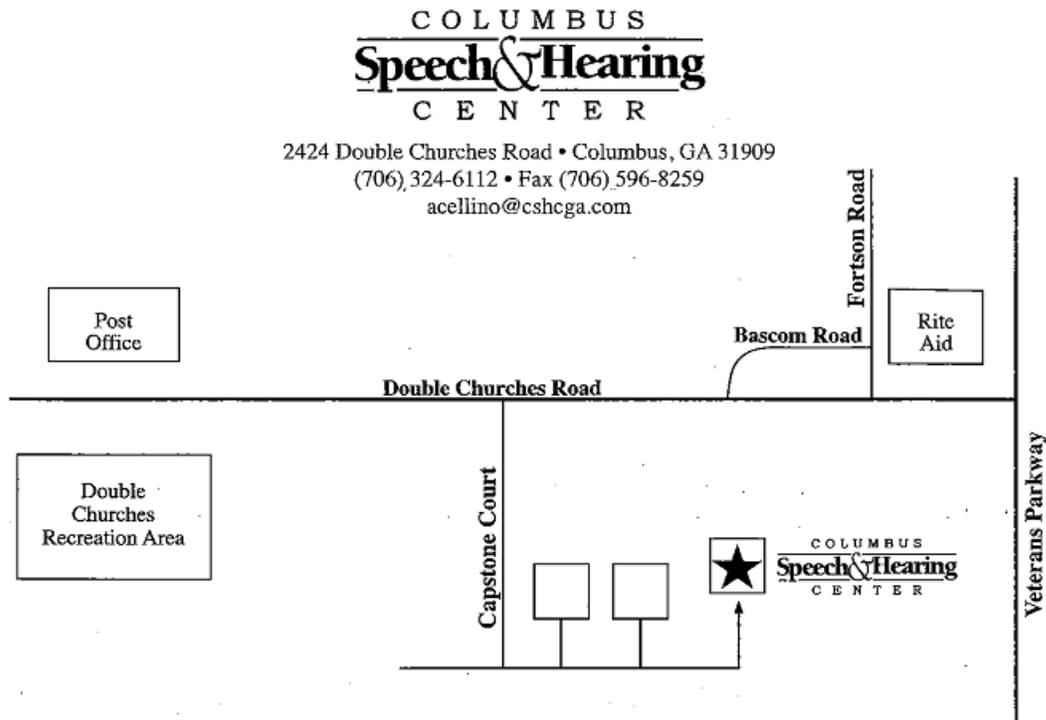
1. *This Cover Letter*
2. *Driving directions to Columbus Speech & Hearing Center*
3. *Diagnostic Vestibular Testing information sheet/Balance testing preparation*
4. *If You Intend to Seek Insurance Reimbursement*

*Materials to return to Columbus Speech & Hearing Center before an initial visit is scheduled:*

1. *Dizzy Questionnaire*
2. *Adult patient intake and insurance information form*
3. *Adult Audiology Case History Form*
4. *Consent to Treat*
5. *Medicare only: Medicare regulations governing outpatient rehabilitation services*
6. *Medicare only: Determining if Medicare is the primary payor*

This letter or e-mail and any attachments may contain confidential and privileged information. If you are not the intended recipient, please notify the sender immediately by return e-mail, delete this e-mail and destroy any copies. Any dissemination or use of this information by a person other than the intended recipient is unauthorized and may be illegal. H: New Patient Form / Adult Audiology Evaluation welcome packet

## Directions to Columbus Speech & Hearing Center



### Coming from LaGrange/Atlanta (I-185 South)

- Take Williams Road, Exit 12
- Turn Left onto Williams Road
- Continue on Williams Rd for almost a mile
- Turn Right onto Fortson Road
- Stay on Fortson until you come to traffic light
- Turn Right onto Double Churches Rd
- Pass Palms Apts on Left; CSHC is next entrance on Left

### Coming from Ft Benning (I-185 North)

- Take Exit 10 towards US-27/US-80/GA22/Macon/Phenix City, Al
- Keep Right to GA-22 East/US-80E ramp towards US-27 Macon
- Keep Right to take Veterans Pkwy ramp
- Turn Right on Veterans Parkway
- Cross over I-185; Turn Left onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance to Left to CSHC

### Coming from East/Midland (JR Allen/US-80)

- Take Exit 4 towards I-185/Atlanta/Ft Benning
- Keep Right to US-27/GA-1/Veterans Pkwy ramp
- Go through traffic light onto Double Churches Road
- Pass North Lake Center and Palms Apts; take next entrance on Left

### Coming from Phenix City (US 80 East)

- Take Exit 4 towards US-27/GA-1/Veterans Pkwy/Moon Road/I-185/Ft Benning/Atlanta
- Stay in Right lane and merge onto Veterans Pkwy/US-27 N/GA-1 toward Hamilton
- Turn Right onto Veterans Parkway
- Turn Left onto Double Churches Road
- Pass North Lake Center and the Palms Apts; take next entrance on the Left



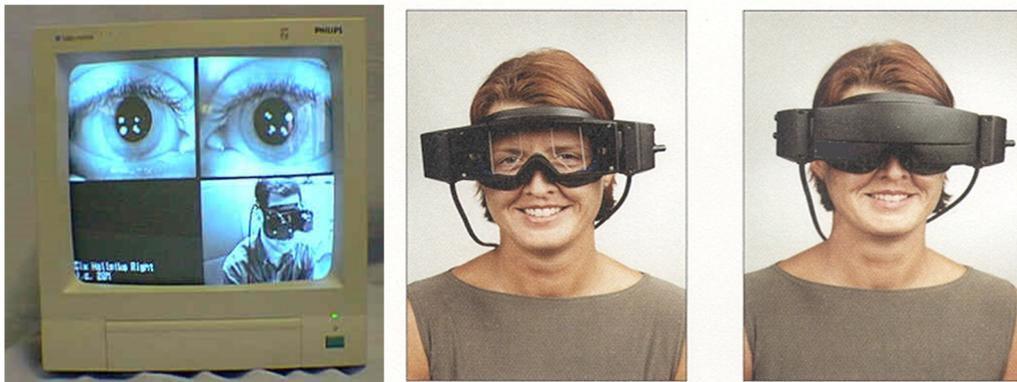
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### Diagnostic Vestibular Testing for Dizzy Patients

Columbus Speech & Hearing Center now provides **videonystagmography** (VNG) testing. VNG testing allows our audiologists to assess problems of dizziness and balance through a battery of tests. During testing, video goggles with infrared cameras record the eye movements of the patient, revealing abnormalities in the balance system.

Previously, eye movement was recorded using electrodes placed on the face around the eyes, known as **electronystagmography** (ENG). Advances in technology have given the VNG several key advantages over the ENG. The use of infrared goggles during VNG testing eliminates confounding physical and environmental noises that confound results obtained with ENG surface electrodes. This allows for a “cleaner” tracing, which is more easily interpreted. The data tracings, normative data and statistical analysis can be sent to the physician for a comprehensive diagnostic picture of the patient’s balance problems.



Testing typically takes place in a ninety minute appointment. First, a thorough case history is taken to better understand the patient’s symptoms. During the test session, a diagnostic audiological evaluation is performed to assess the functioning of seven main tests: gaze, saccades, horizontal tracking, optokinetic nystagmus, positional, Dix-Hallpike maneuvers, and calorics.

- **Spontaneous Gaze/Nystagmus Test**

The Spontaneous Gaze/Nystagmus Test is designed to determine if a patient’s eye-motor system, or the specific reflexes between the inner ear and the eye, is normal. The first portion of this test is performed by having the patient track a moving target by only moving their eyes. During the second portion of the test, the patient holds their eyes on a target while moving their head in a specific pattern. The third portion of this test is performed by evaluating a patient’s ability to hold their eyes straight forward when their eyes are shut.

- **Saccade Test**

The Saccade Test is designed to observe the velocity, accuracy, and latency of rapid eye movements from one target to another.

- **Optokinetic Nystagmus Test**

The Optokinetic Nystagmus test evaluates a patient’s ability to track moving objects with their eyes. This test evaluates functions of the brain to determine if this damage may cause an abnormal influence on the balance systems and the brainstem.

- **Bithermal Caloric Testing**

The Bithermal Caloric Testing exam is used to determine if one ear has a weaker balance canal than the other, or if both sides have an impaired response causing dizziness or imbalance. The test is administered with the patient in a reclining position. Each ear canal is alternately irrigated with cool and warm air for 60 seconds, which causes the lateral semicircular canal of the inner ear to be stimulated. The stimulation normally results in beating eye movements called nystagmus, which occur since the brain is tricked into thinking the patient is rotating. The responses of the balance mechanism are calculated through the strength of the beating eye movements (nystagmus).

- **Positional Testing**

The Positional Test is used to evaluate the balance system by recording the patient's eye movements as they are placed in certain positions and/or moved into different positions. These tests aid the physician in determining the stability of the balance system as it adapts to new positions. This test is also useful in identifying signs of benign paroxysmal positional vertigo (BPPV), one of the more common types of vertigo.

The audiologist may also work with the physician, otolaryngologist or other professionals to develop and direct individual vestibular rehabilitation programs. There are several types of vestibular disorders that may be helped by vestibular rehabilitation.

Please contact me if you have any suggestions on how we may better serve your patients receiving VNG assessments. We want our services to be coordinated with your and seamless for the patients. As always, we appreciate your support.



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### Balance Testing Preparation

Patient: \_\_\_\_\_ Appointment date: \_\_\_\_\_ Time: \_\_\_\_\_

You have been scheduled for a test of your balance mechanism. The examination is a simple, painless procedure requiring about an hour. The test will involve moving the head and body into different positions, as well as stimulating the ears with cool and warm water. If you have any problems with your neck or back, please inform us prior to the beginning of the evaluation. This test will likely cause some dizziness that generally passes within a few minutes. In rare instances, the dizziness lasts a little longer, making it inadvisable to drive for a short time. You should make arrangements for someone to be available to come drive you home in the event you are unable to do so. Instructions below are intended to prepare you for the testing so you will be as comfortable as possible, and to avoid anything that may interfere with the test results. Please read them carefully. Call our audiologists (706-327-7592) if you have questions.

- It is imperative that you **DO NOT** take any anti-vertigo and anti-dizziness medications for 48 hours (2 days) prior to testing. These medications include Antivert, Meclizine, Bonine, Dramamine, Scopolamine and antihistamines – both over the counter and prescription forms of these medications.
- Please **DO NOT** discontinue any prescription medication without checking with the physician who prescribed it. If you cannot go without a medication listed above, please call one of our audiologists at (706) 327-7592 to discuss this prior to coming to the evaluation.
- Abstain from alcohol for 48 hours before testing. **All** alcoholic beverages affect the results of this test.
- No eating drinking, or smoking for 3 hours prior to the time of your appointment.
- Do not** wear any eye make-up, including eyeliner or mascara.

Please dress comfortably. Women may wish to wear slacks. If you wear contact lenses, please bring your glasses with you in case you need to remove your lenses. You may also wish to bring your eyeglass holder.



# Medical History

## Neurologic

- Migraine
- Stroke/TA: If so When \_\_\_\_\_
- Parkinson's Disease
- Seizures/ Epilepsy
- Concussion/Head Injury: when \_\_\_\_
- Multiple Sclerosis
- Alzheimer's
- Other \_\_\_\_\_

## Cardiovascular

- Heart Attack: If so when \_\_\_\_\_
- Pacemaker
- Peripheral Arterial Disease
- High Blood Pressure
- Low Blood Pressure
- Other Cardiovascular \_\_\_\_\_

## Respiratory

- Breathing Difficulties
- Emphysema/COPD
- Asthma
- Other Respiratory \_\_\_\_\_

## Orthopedic

- Artificial Joints if yes which \_\_\_\_\_
- Arthritis
- Back Problems
- Back Surgery – When
- Neck Problems
- Osteoporosis/Osteopenia

## Vision

- Cataracts – if so when \_\_\_\_\_
- Glaucoma
- Macular Degeneration
- Other Vision \_\_\_\_\_

## Other

- Cancer: Type \_\_\_\_\_
- Diabetes
- Neuropathy
- Depression
- Anxiety
- Thyroid
- Gastrointestinal Problems
- Rheumatoid Arthritis
- Tobacco Use: How Much \_\_\_\_\_
- Alcohol Use: How Much \_\_\_\_\_



# Patient Questionnaire

pg. 1/2

Equilibrium disorders may appear with a variety of symptoms. Some individuals may experience dizziness or vertigo while others may have imbalance or unsteadiness. Please spend a few minutes answering the questions regarding your history and symptoms. Answer the questions to the best of your ability but please be assured that how you answer will not affect your evaluation.

How or when did your problem first occur? \_\_\_\_\_

How long did it last? \_\_\_\_\_

1. Do you experience any of the following sensations? Please read the entire list first. Then put an x in either the first box for YES or the second box for NO to describe your feelings most accurately.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Do you experience motion, air or sea sickness?
<input type="checkbox"/>	<input type="checkbox"/>	Did you have motion sickness as a child?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have a family history of motion sickness? Parent ___ Sibling ___ Child ___
<input type="checkbox"/>	<input type="checkbox"/>	Do you have migraine headaches?
<input type="checkbox"/>	<input type="checkbox"/>	Where you exposed to any solvents, chemicals, etc.?
<input type="checkbox"/>	<input type="checkbox"/>	Have you ever fallen? If so how many times? _____
		Where did you fall? _____ Inside the home _____ Outside the home _____
<input type="checkbox"/>	<input type="checkbox"/>	Are you afraid of falling?

2. If you have dizziness, please check the box for either YES or NO, and fill in the blank spaces. If you do not experience dizziness, please go to the next section

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	My dizziness is constant. If you answered yes, please go to question 3.
<input type="checkbox"/>	<input type="checkbox"/>	Are you completely free of dizziness between attacks? How often are your dizziness attacks? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you have any warning that the attack is about to start?
<input type="checkbox"/>	<input type="checkbox"/>	Is the dizziness provoked by head/body movement? If so which direction? _____
<input type="checkbox"/>	<input type="checkbox"/>	Is the dizziness worse at any particular time of day? If so when? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know of anything that will stop your dizziness or make it better? What? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know of anything that will make your dizziness worse? What? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know of anything that will precipitate an attack? What? _____
<input type="checkbox"/>	<input type="checkbox"/>	Do you know any possible cause of your dizziness? What? _____ _____



3. Do you experience any of the following sensations? Please read the entire list first then please check the box for either YES or NO to describe your feelings most accurately.

YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Light headaches?
<input type="checkbox"/>	<input type="checkbox"/>	Swimming sensation in the head?
<input type="checkbox"/>	<input type="checkbox"/>	Blacking out or loss of consciousness?
<input type="checkbox"/>	<input type="checkbox"/>	Objects spinning or turning around you?
<input type="checkbox"/>	<input type="checkbox"/>	Sensation that you are turning or spinning inside, w/ outside objects remaining stationary?
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to fall to the right or left?
<input type="checkbox"/>	<input type="checkbox"/>	Tendency to fall forward or backward?
<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance when walking, veering to the right?
<input type="checkbox"/>	<input type="checkbox"/>	Loss of balance when walking, veering to the left?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have trouble walking in the dark?
<input type="checkbox"/>	<input type="checkbox"/>	Do you have problems turning to one side or the other?
<input type="checkbox"/>	<input type="checkbox"/>	Nausea or vomiting?
<input type="checkbox"/>	<input type="checkbox"/>	Pressure in the head?

4. Have you ever experienced any of the following symptoms? Please check the box for either YES or NO and circle if Constant or if in Episodes

YES	NO		Constant	In Episodes
<input type="checkbox"/>	<input type="checkbox"/>	Double vision		
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision or blindness?		
<input type="checkbox"/>	<input type="checkbox"/>	Spots before your eyes?		
<input type="checkbox"/>	<input type="checkbox"/>	Numbness of face, arms or legs		
<input type="checkbox"/>	<input type="checkbox"/>	Weakness in arms or legs?		
<input type="checkbox"/>	<input type="checkbox"/>	Confusion or loss of consciousness?		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing? Tingling around the mouth?		
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Speaking		

5. Do you have any of the following? Please check the box YES or NO & circle the ear involved.

Yes	No		Both	Right	Left
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty in hearing?			
<input type="checkbox"/>	<input type="checkbox"/>	When did this start? _____	Is it getting worse? Y or N		
<input type="checkbox"/>	<input type="checkbox"/>	Does the hearing change with your symptoms?	If so how? _____		
<input type="checkbox"/>	<input type="checkbox"/>	Noise in your ears?			
<input type="checkbox"/>	<input type="checkbox"/>	Describe the noise? _____			
<input type="checkbox"/>	<input type="checkbox"/>	Does the noise change w/ your symptoms?	If so how? _____		
<input type="checkbox"/>	<input type="checkbox"/>	Does anything stop the noise or make it better?	_____		
<input type="checkbox"/>	<input type="checkbox"/>	Fullness or stuffiness in your ears?			
<input type="checkbox"/>	<input type="checkbox"/>	Does this change when you are dizzy?	Y or N		
<input type="checkbox"/>	<input type="checkbox"/>	Pain in your ears?			
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from your ears?			



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## CONSENT TO TREAT SIGNATURE PAGE

Patient Name:

DOB:

Age:

Account:

**Instructions:** Please initial beside each of the following items, indicating your authorization or agreement.

Initials	
	<p><b>CONSENT FOR TREATMENT:</b></p> <p>I hereby consent to such diagnostic procedures, and medical treatment, which in the judgment of my Physicians may be considered necessary or advisable while a patient at Columbus Speech and Hearing Center</p>
	<p><b>ASSIGNMENT OF BENEFITS:</b></p> <p>I hereby authorize payment directly to Columbus Speech &amp; Hearing Center of the medical benefits, otherwise payable to me for services described above, but not to exceed reasonable and customary charges for those services. I understand and acknowledge that this assignment does not necessarily relieve me of my financial responsibility.</p>
	<p><b>AGREEMENT TO PAY:</b></p> <p>I agree to pay all monies due to Columbus Speech and Hearing Center at the time services are rendered or upon receipt of an invoice for services rendered by Columbus Speech and Hearing Center. If payment has not been received from my insurance carrier(s), I also accept personal liability for such charges.</p>
	<p><b>AUTHORIZATION TO RELEASE INFORMATION:</b></p> <p>I consent to the release of relevant diagnostic, therapy, or other related materials to qualified professional personnel in furtherance of clinical services on behalf of me or my minor being seen; or for whom I am legally responsible, as deemed medically necessary by the attending Speech-Language Pathologist, Occupational Therapist, and/or Audiologist at Columbus Speech and Hearing Center.</p>
	<p><b>ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:</b></p> <p>I have reviewed the <i>Notice of Privacy Practices</i> as provided by Columbus Speech and Hearing Center.</p>
	<p><b>CONSENT TO RECEIVE STATEMENTS AND BILLING COMMUNICATION VIA TEXT &amp; EMAIL:</b></p> <p>I hereby authorize the staff of Columbus Speech and Hearing Center to send me billing statements for services rendered (when applicable) via text and/or email and to correspond to me regarding my statement via telephone, text messaging, and/or email.</p>
	<p><b>CONSENT FOR PICTURES:</b></p> <p>I agree to allow you to help celebrate me and/or my child's success via posting pictures of me or my likeness on the Columbus Speech and Hearing Center social media platform. I understand that Columbus Speech and Hearing Center will show me these specific photographs for my approval prior to the post.</p>

I do hereby verify that this electronic signature (s) is authentic (when applicable), & information herein is being submitted by me.

\_\_\_\_\_  
\*Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness



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## ADULT PATIENT INTAKE AND INSURANCE INFORMATION

<b>LAST NAME</b>	<b>FIRST NAME</b>	<b>MI</b>	<b>BIRTHDATE</b>
<b>PRIMARY CARE PHYSICIAN</b>		<b>SOCIAL SECURITY NUMBER</b>	<b>SEX</b>

<b>ADDRESS:</b>
<b>OCCUPATION:</b>
<b>EMPLOYER:</b>
<b>HOME PHONE:</b>
<b>CELL PHONE:</b>
<b>WORK PHONE:</b>
<b>EMAIL:</b>

## INSURANCE IDENTIFYING INFORMATION

	<b>PRIMARY INSURANCE</b>	<b>SECONDARY INSURANCE</b>
<b>NAME OF INSURANCE</b>		
<b>NAME OF POLICY HOLDER</b>		
<b>RELATIONSHIP TO PATIENT</b>		
<b>POLICY NUMBER</b>		
<b>GROUP NUMBER</b>		
<b>PROVIDER CUSTOMER SERVICE NUMBER</b>		
<b>PLAN TYPE: HMO, POS, PPO</b>		

## PATIENT VERIFICATION OF ACCURATE INSURANCE INFORMATION AND RESPONSIBILITY FOR PAYMENT

I understand and agree that I am ultimately responsible for payment in full for any professional services rendered, regardless of my insurance status. The information listed above is true and accurate to the best of my knowledge. I understand that all claims are subject to individual contract policy and to medical necessity review. Prior authorization for a procedure is not a guarantee of payment. I will promptly notify you of any changes in my health care coverage or the above information.

I do hereby verify that this electronic signature is authentic (where applicable), and the information herein is being submitted by me

s/s \_\_\_\_\_  
Name Date



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## Adult Audiology Case History

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's Date: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_ Name of spouse or friend with you today? \_\_\_\_\_

Referral source: \_\_\_\_\_ To whom should reports go: \_\_\_\_\_

Check any of the following that you currently have, or have had:			
High blood pressure	<input type="checkbox"/>	Heart disease	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	Mumps	<input type="checkbox"/>
Meningitis	<input type="checkbox"/>	General anesthetic	<input type="checkbox"/>
		Stroke	<input type="checkbox"/>
		Kidney disease	<input type="checkbox"/>
		Measles	<input type="checkbox"/>
		Head Trauma	<input type="checkbox"/>

1. List any chronic illnesses: \_\_\_\_\_

2. List all current medications: \_\_\_\_\_

3. How is your current health? \_\_\_\_\_

4. Was the onset of your hearing loss sudden or gradual? \_\_\_\_\_

5. Who first noticed your hearing problem? \_\_\_\_\_ When? \_\_\_\_\_

6. Describe any medical treatment you may have had for your hearing problem: \_\_\_\_\_

7. In which ear do you hear better? Left \_\_\_\_\_ Right \_\_\_\_\_

8. Do you have tinnitus (ringing, buzzing, hissing) sounds in your ear? Yes \_\_\_\_\_ No \_\_\_\_\_

9. In which ear does it occur? Left \_\_\_\_\_ Right \_\_\_\_\_ Both \_\_\_\_\_

10. When did you first notice it? 1-3 years \_\_\_\_\_ 4-10 years \_\_\_\_\_ More than 10 years \_\_\_\_\_

11. How often does your tinnitus occur? \_\_\_\_\_

12. When was the last time you had your hearing tested? \_\_\_\_\_ Where? \_\_\_\_\_

13. Why have you decided to have your hearing tested at this time?

a. I feel my hearing is poor and may need to be aided

b. Family/friends have suggested I have my hearing tested.

c. Other/explain: \_\_\_\_\_

14. If you wear hearing aids:

a. In which ear? Left only \_\_\_\_\_ Right only \_\_\_\_\_ Both ears \_\_\_\_\_

b. When did you buy your hearing aids? \_\_\_\_\_

c. Approximately how many hours a day do you wear them? \_\_\_\_\_

d. Do you have any problems with your aids? \_\_\_\_\_ If Yes, explain: \_\_\_\_\_

Yes	No	<i>Please check yes or no. For "Yes" answers to the following questions, please explain</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Have you been exposed to loud noise for long periods of time?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Does anyone in your family have hearing loss?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Do you have dizziness, vertigo or loss of balance?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Have you ever worn a hearing aid?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Did you have chronic ear infections as a child or adult?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Do your ear canals itch?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Have you had any falls within the last 12 months? If so how many?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Do you use tobacco products? If so how often?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Do you have tubes or holes in your eardrum?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Do you have sinus or allergy problems?</i>
<input type="checkbox"/>	<input type="checkbox"/>	<i>Do you have pain or discomfort in your ears?</i>
		<i>Do you have difficulty when:</i>
<input type="checkbox"/>	<input type="checkbox"/>	a. <i>Someone speaks in a whisper?</i>
<input type="checkbox"/>	<input type="checkbox"/>	b. <i>Visiting friends, relatives or neighbors?</i>
<input type="checkbox"/>	<input type="checkbox"/>	c. <i>Listening to TV or radio?</i>
<input type="checkbox"/>	<input type="checkbox"/>	d. <i>Listening to children or women?</i>