HEARING LOSS QUESTIONNAIRE

Name: _____ Date: _____

Date of Birth: _____

When did you first begin to experience your hearing loss? _____

I. PLEASE CHECK THE SPACES BELOW THAT APPLY TO YOUR HEARING LOSS:

☐ Did the hearing loss come on

☐ suddenly (over three days) or ☐ quickly (weeks and months) or ☐ gradually (months or years)?

Is your hearing loss on the ☐ right, on the ☐ left or ☐ on both sides?

If on both sides, is your hearing worse on the ☐ right or ☐ left?

II. PLEASE INDICATE YOUR ANSWER BY CHECKING "YES" OR "NO."

YES	NO	
___	___	Does your family have a history of hearing loss?
___	___	Have you been exposed to loud noises over a long period of time?
___	___	Do you hunt or shoot recreationally?
___	___	Have you ever had ear surgery? If so, please describe: _____
___	___	Do you use large amounts of aspirin?
___	___	Do you use large amounts of caffeine?
___	___	Have you ever had to be on IV antibiotics for serious infections?
___	___	Have you had a ☐ cold, ☐ allergies or ☐ sinus problems shortly before the hearing loss began?
___	___	Have you had an ear trauma or head injury prior to hearing loss?
___	___	Is your hearing loss getting worse?

III. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS? PUT AN "X" IN EITHER THE FIRST BLANK FOR "YES" OR THE SECOND BLANK FOR "NO" AND CIRCLE THE EAR INVOLVED.

YES	NO				
___	___	1. Noise in your ears?	Both ears	Left	Right
		Describe the noise _____			
___	___	2. Fullness or stuffiness in your ears?	Both ears	Left	Right
___	___	3. Pain in your ears?	Both ears	Left	Right
___	___	4. Drainage from your ears?	Both ears	Left	Right
___	___	5. Distortion of sound?	Both ears	Left	Right
___	___	6. Sensitivity to sound?	Both ears	Left	Right
___	___	7. Do you have dizziness? If so, please describe your dizziness: _____			

_____

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