HEARING LOSS QUESTIONNAIRE

NAME:_____ DATE:_____

DOB:_____

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

I. Please check the spaces below which apply to your hearing loss:

Did the hearing problem come on ____ suddenly (over three days) or

____ quickly (weeks and months) or ____ gradually (months or years)?

Your hearing problem is ____ on the right, ____ on the left, or ____ on both sides?

If both sides, hearing is worse on the ____right or ____left?

II. Please indicate your answer by check "Yes" or "No".

Yes No

___ ___ Does your family have a history of hearing problems?

___ ___ 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, ___ sinus problems shortly before hearing loss began?

___ ___ Have you had an ear trauma or head injury prior to hearing loss?

___ ___ Is your hearing problem 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 Right Left
Describe the noise:_____

___ ___ 2. Fullness or stuffiness in your ears? Both ears Right Left

___ ___ 3. Pain in your ears? Both ears Right Left

___ ___ 4. Drainage from your ears? Both ears Right Left

___ ___ 5. Distortion of sound? Both ears Right Left

___ ___ 6. Sensitivity to sound? Both ears Right Left

___ ___ 7. Do you have dizziness? If so, please describe your dizziness: _____
_____