The Hearing and Balance Clinic

Affiliated with Ear, Nose and Throat

Associates of Northern Colorado

EAR SYMPTOMS QUESTIONNAIRE

Name: ______________________________ Age:_________ Date: ____________________

Please answer the following questions carefully.

	YES	NO	**Please describe if YES**
1. Do you have ear pain?			
2. Do you have a stopped up or pressure feeling in your ears?			
3. Has either or both of your ears ever drained (other than normal ear wax)?			
4. Do you have a hearing loss that you are aware of?			
5. Did it begin **suddenly** or **gradually**?			
6. Do you Have difficulty understanding words?			
7. Do you have **ringing** or **buzzing** in the ears, if so, does it come and go?			
8. Have you had loud noise exposure in your lifetime, if so, what kind?			
9. Have you taken **medications** or **antibiotics** that affected your hearing?			
10. Have you or do you currently wear hearing aids?			
11. Do you have blood relation with a hearing loss?			
12. Do you have dizzy spells?			
13. Have you ever had a head or ear injury, if so, any **X-rays**?			
14. Have you ever had an ear operation?			
15. Do you have dental problems or grind your teeth?			
16. Did you have earaches as a child?			
17. Have you ever or do you currently smoke, How much?			
18. Have you had any recent hearing tests, if so when and where?			