Patient Name  Age  Date

Please answer the questions to the best of your knowledge.

1. How long have you noticed hearing loss?

2. Is the hearing loss present in both ears? Yes  No  If NO, which ear has the loss?  L  R

3. Was the hearing loss sudden in onset or gradual?

4. Does your hearing seem to be better at certain time and worse at other times? Yes  No

5. Do you have any noise in your ear(s)? Yes  No  If yes, describe the noise

6. Do your ears feel as if they are full or have pressure? Yes  No

7. Has there been any dizziness associated with the hearing loss? Yes  No

   If yes, does your hearing decrease when you get dizzy? Yes  No

   Is your dizziness a light-headedness or a spinning dizziness? Light-headedness  Spinning

8. Have you had a past history of ear problems? Yes  No

   Pain  Yes  No

   Infection  Yes  No

   Drainage  Yes  No

   Other (explain)  

9. Is there a family history of hearing loss? Yes  No

   If yes, give relationship of person with hearing loss and approximate age hearing loss was found

10. Have you worked where ear plugs were required to be worn because of loud noise? Yes  No

11. Have you ever been given IV drugs for a severe infection or taken any other drugs which seem to have affected your hearing? Yes  No