Lawrence Otolaryngology Associates, LLC
Hearing Loss Questionnaire

NAME: _____ DATE:_____

Please answer these questions so we can better understand your concerns.

1) Did your hearing loss come on rapidly _____ or slowly _____?
2) Does your hearing loss change from day to day? Yes ___ No_____
3) Is your hearing loss associated with any dizziness or balance troubles? Yes _____No_____
4) Is your hearing loss associated with any ringing or buzzing in the ear? Yes____No_____
5) Is there any associated pressure or fullness in the ear? Yes___ No____
6) Is there any drainage from either ear? Yes___No___
7) Is there pain in either ear? Yes____No____

Sometimes things that have happened in the past can affect your hearing:

1) Have you ever had ear surgery? Yes___No____
2) Have you ever been treated for Tuberculosis? Yes____No____
3) Have you ever been treated for syphilis? Yes___No____
4) Have you ever had to take thyroid hormone pills? Yes___No____
5) Have you ever been hospitalized with a bad infection and had to take IV antibiotics? Yes___No____
6) Have you ever taken chemotherapy for cancer? Yes___No____
7) Have you been exposed to large amounts of noise such as working in a factory, repeatedly shooting guns, going to loud concerts, working with loud engines? Yes___No____
8) Have you had repeated ear infections? Yes___No____
9) Have you had a smoking habit? Yes____No_____
10) Have you ever been knocked out and taken to the hospital? Yes___No____
11) Have you had any recent heavy lifting more than 20 pounds? Yes___No____

In the past month, how much of these items do you take each day?

1) Aspirin: none 1-5 tablets more than six tablets
2) Ibuprofen/Motrin/Aleve: none 1-5 tablets more than six tablets
3) Caffeine: none 0-16 oz. more than 16 oz.
4) Salt: none add a little/one salty food add a lot/more than one salty food