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The ComprEhensive ENT Center of Texas

Hearing Loss Questionnaire

www.drleeman.com

Patient Name _____ Age_____Date_____

1. Howlonghaveyounoticedyourhearingloss?_____
2. Is the hearing loss present in both ears? Yes _____ No _____ If NO, which ear has the loss? L _____ R _____
3. Wasthehearinglosssuddeninonsetorgradual?_____
4. Does your hearing seem to be better at certain time and worse at other times? Yes _____ No _____

   If so, when?_____
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 _____

    If yes, how often did you wear ear plugs? (check one)
    q Never
    q Less than 25% of the time
    q 25-50 % of the time
    q 50-75% of the time
    q More than 75% of the time
    q Always
11. Have you been exposed to any abnormally loud noises? (gun shots, explosions, etc.)? Yes _____ No _____
12. HaveyoueverbeengivenIVdrugsforasevereinfectionortakenanyotherdrugswhichseemtohaveaffectedyourhearing? Yes _____ No _____