

Fayetteville Otolaryngology – Head and Neck Surgery, P.A.

Hearing Loss Questionnaire

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 ___