SCOTCH INSTITUTE
ENT | Hearing | Allergy | Sleep

Hearing Questionnaire

Patient Name: ____ Date: ________________

1. Do you have difficulty hearing?
   a. Both ears? Y or N
   b. Right ear? Y or N
   c. Left ear? Y or N
2. Do you wear hearing aids?
   a. Right Hearing Aid? Y or N
   b. Left Hearing Aid? Y or N
3. When did you first notice your hearing loss? ____________________________________
4. Is your hearing getting worse? Y or N
5. Does your hearing fluctuate? Y or N
6. Do you hear any noise in your ears? Y or N
7. Do you have any ear pain? Y or N
8. Do you have any sensitivity to sound? Y or N
9. Do you have distortion of sound? Y or N
10. Do you have any fullness or stuffiness in your ears? Y or N
11. Do you have any ear drainage? Y or N
12. Have you had any ear surgery? Y or N
    a. If yes, what type?____ (Examples of common ear surgeries include ear tubes, Tympanoplasty, mastoidectomy, stapedectomy)
13. Have you ever worked in high noise level area? Y or N
14. Have you ever had any head or ear trauma? Y or N
    a. If yes, what type?____
15. Have you been exposed to noise from weapon fire, blasts, or military occupational noise? Y or N
16. Do you have anyone in your family that is deaf or has severe hearing loss? Y or N
17. Circle any of the following medications you have taken:
    a. Streptomycin g. Salicylates (aspirin)
    b. Tobramycin (Neecin) h. Birth Control Pills
    c. Gentamycin (Garamycin) i. Blood Pressure Pills
    d. Kanamycin (Kantrey) j. Anti-Seizures medications
    e. Ethacrinic Acid (Edecrin) k. Anti-Cancer medication
    f. Furosemide (Lasix)

The above comprehensive history has been personally reviewed by the below listed doctors:

Physician's Signature: _________________ Date: _______________________________

Audiologist's Signature: ______________ Date: ______________________________