

**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