LAWRENCE OTOLARYNGOLOGY ASSOCIATES
Adult Ear Infection Questionnaire
Information must be filled out prior to being seen

Patient Name: _____ Date: _____

1) What have you noticed about your infection? (circle all that apply)
   A. Pain
   B. Drainage
   C. Itchiness
   D. Decreased hearing

2) What have you done for this infection? (circle all that apply)
   A. Flushed ear
   B. Taken ear drops. Please list:
      1._____ 2. _____

   C. Taken Antibiotics. Please list:
      1. _____ 2. _____

   D. Other _____

3) Please list the antibiotics you have taken for ear infections in the last year.

	Name of Medication	**Date Started**	**Date Ended**
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____
D.	_____	_____	_____
E.	_____	_____	_____
F.	_____	_____	_____
G.	_____	_____	_____

4) Do you believe your hearing is affected? Yes / No

5) Do you believe your speech is affected? Yes / No

6) Has your eardrum ruptured? Yes / No

7) Do you have nasal blockage? **(Circle all that apply)**
   A. No B. Yes, with snoring
   C. Yes, with mouth breathing D. Yes, with snoring and stopping breathing at night

8) Are you exposed to tobacco smoke? Yes/No

9) What other family members have had problems with ear infections? **(Circle all that apply)**
   A. Mom B. Dad C. Sister or Brother D. Aunt E. Uncle F. Grandparents