Proliance South Seattle Otolaryngology

Ear Questionnaire

Name: _____ Date: _____

Do you have any hearing loss?	Y	N	Right	Left
Do you have any ear pain?	Y	N	Right	Left
Do you notice any drainage from the ear?	Y	N	Right	Left
Do you have any ringing in the ear?	Y	N	Right	Left
Do you have ear itching?	Y	N	Right	Left
Do you have any pressure in your ear?	Y	N	Right	Left
Do you notice any whirling vertigo?	Y	N		
Have you had previous ear infections?	Y	N	Right	Left
Have you ever had ear or head related trauma (ie: concussion)	Y	N	Right	Left
Have you ever had any ear surgeries?	Y	N	Right	Left
Do you have any family history of ear disease or hearing loss?	Y	N		
Have you been exposed to any significant loud noise for a prolonged period of time (ie: car engines, loud work environment, guns, loud music, etc.)	Y	N		
Have you ever been treated with chemotherapy	Y	N		

Over the past month, how much has each of the following been a problem for you (on a scale of 1-10, with 1 indicating no problem and 10 indicating a severe problem)

Pressure is the ears?	0 1 2 3 4 5 6 7 8 9 10
Pain in ears?	0 1 2 3 4 5 6 7 8 9 10
A feeling that your ears are clogged or “under water”?	0 1 2 3 4 5 6 7 8 9 10
Ear symptoms when you have a cold or sinusitis?	0 1 2 3 4 5 6 7 8 9 10
Crackling or popping sounds in the ear?	0 1 2 3 4 5 6 7 8 9 10
Ringing in ears?	0 1 2 3 4 5 6 7 8 9 10
A feeling that your hearing is muffled?	0 1 2 3 4 5 6 7 8 9 10

Total: _____

Do you grind or clench your teeth?	____ Yes	____ No
Do you wear a dental guard?	____ Yes	____ No