Richard W. Waguespack, MD

OTOLOGIC (Ear) QUESTIONNAIRE

Name: ______________________________

Date: _________________________

Please print and complete to help us to obtain your history.

Please circle response: How long have you had this problem? _________________________________

Yes No Do you know anything that might have caused your problem?

If yes, what? ____

Right Left Which ear is causing your problem?

Yes No Do you have trouble **hearing**?

Yes No Do you have more trouble with **understanding** what others are saying?

Yes No Do you have ear **pressure** or fullness?

Yes No Do you have **pain** in the ears? ☐ Yes ☐ No Do you have **ringing** or noise?

If yes, what does it sound like? ____

Yes No Do you have **drainage** from you ear(s)? If yes, what kind? _____________________

Yes No Do you have **dizziness,** loss of balance or vertigo **along with your ear symptoms**?

Yes No Do any close **family** members have hearing loss? If yes, what kind? _____________

Yes No Have you been exposed to **loud noises** or explosions at any time in your life?

Yes No Within the past 24 hours? Please explain ___________________________________

Yes No Have you ever taken any **medicines** that might have harmed our hearing? (Streptomycin, gentamicin, and quinine are examples) If yes, what kind? ____________________________

Yes No Do you take much **aspirin** or aspirin-containing medication such as Bufferin or Ascriptin? If yes, how much each day? _____________________________________

Yes No Has your hearing been checked lately? If yes, when and where? __________________

Yes No Have you tried using **hearing aid(s)**?

Please list **all medicines and treatments** given for your ear problem. ☐ None

____

____

____

Comments: