Hearing Screening Questionnaire

- **YES** ☐  **NO** ☐  Had you had draining from your ear in the last 3 months (90 days)?
- **YES** ☐  **NO** ☐  Had you had rapidly progressing hearing loss in the last 3 months (90 days)?
- **YES** ☐  **NO** ☐  Had you had sudden hearing loss in the last 90 days?
- **YES** ☐  **NO** ☐  Had you had a history of any head trauma?  When?  How?
- **YES** ☐  **NO** ☐  Had you had a history of ear pain, pressure or fullness recently?
- **YES** ☐  **NO** ☐  Have you had a history of ear infections?
- **YES** ☐  **NO** ☐  Have you had a history of any ear surgery?  When?  Why?
- **YES** ☐  **NO** ☐  Do you experience frequent dizziness, vertigo, or loss of balance?
- **YES** ☐  **NO** ☐  Do you have any ringing, buzzing or hissing in your ears?
- **YES** ☐  **NO** ☐  Do you have a history of noise exposure?  (i.e. machine operator)
- **YES** ☐  **NO** ☐  Do you feel you hear better in one ear than the other?
- **YES** ☐  **NO** ☐  Have you ever worn a hearing aid?  When?
- **YES** ☐  **NO** ☐  Do you have any deformity / abnormality of the outer ear structure, ear canal, inner ear, or tympanic membrane?  What kind?
- **YES** ☐  **NO** ☐  Do you get significant ear wax accumulation in the external auditory canal / ear?
- **YES** ☐  **NO** ☐  Do you have a foreign body in the external auditory canal?  What kind?  Since when?