ROBERT T. SATALOFF, M.D., D.M.A., F.A.C.S.
KAREN M. LYONS, M.D.
BRIAN J. McKINNON, M.D., M.B.A., M.P.H., F.A.C.S.

Education/Research
Drexel University College of Medicine
American Institute for Voice and Ear Research
Clinical Care
Philadelphia Ear, Nose & Throat Associates, L.L.C.

219 N. Broad Street, 10th Floor
Philadelphia, PA 19107

E-mail: frontdesk@phillyent.com
www.PhillyENT.com

(215) 762-5530 / (215) 545-3322
Fax: (215) 762-5540

PATIENT HISTORY: HEARING LOSS

NAME: _____ AGE: _____ DATE: _____

Hearing loss, dizziness, tinnitus (noises) and ear pain may be associated with a variety of problems. Your answers to the following questions will help establish the exact cause of your problem. Please answer all of the questions and please give precise details when requested.

PLEASE CHECK AND/OR CIRCLE THE APPROPRIATE ANSWERS ON THIS QUESTIONNAIRE.

RIGHT	LEFT				
_____	_____	1. IN WHICH EAR DO YOU HAVE HEARING LOSS?			
_____	_____	2. HOW LONG HAVE YOU HAD A HEARING LOSS? PLEASE DESCRIBE:			
_____	_____	3. WHO FIRST NOTICED YOUR HEARING LOSS? _____ You _____ Family Member _____ Others			
YES	NO			RIGHT	LEFT
_____	_____	4. HEARING DECREASE:	Slowly	R	L
			Rapidly	R	L
			Sudden Loss	R	L
_____	_____	5. HEARING STABLE FOR MANY YEARS		R	L
_____	_____	6. DISTORTION OF PITCH		R	L
_____	_____	7. ARE YOU BOTHERED BY LOUD NOISES?		R	L
_____	_____	8. TROUBLE UNDERSTANDING SPEECH		R	L
_____	_____	9. CANNOT USE EAR ON TELEPHONE		R	L
_____	_____	10. FLUCTUATING HEARING (GOOD AND BAD DAYS)		R	L
_____	_____	11. FEELING OF FULLNESS IN YOUR EARS		R	L
_____	_____	12. DOES IT FLUCTUATE WITH YOUR HEARING?		R	L
_____	_____	13. ANYTHING MAKE IT BETTER OR WORSE? DESCRIBE:		R	L
_____	_____	14. HEARING CHANGES WITH STRAINING, BENDING, NOSE BLOWING OR LIFTING?		R	L

_____	_____	15. EAR PROBLEMS AS A CHILD. DESCRIBE:	R	L
_____	_____	16. DRAINING EARS AT ANY TIME. DESCRIBE:	R	L
_____	_____	17. RECENT OR FREQUENT EAR INFECTIONS	R	L
_____	_____	18. HAVE YOU EVER HAD EAR SURGERY? DESCRIBE: (GIVE DATES)	R	L
_____	_____	19. EAR SURGERY SCHEDULED BUT NOT PERFORMED?	R	L
_____	_____	20. HAD A DIRECT INJURY TO YOUR EAR? IF YES, WHEN? _____ PLEASE DESCRIBE:	R	L
_____	_____	21. SEVERE HEAD INJURY?		
_____	_____	22. IF YOU EXPERIENCED SEVERE HEAD INJURY, WAS THERE LOSS OF CONSCIOUSNESS? IF YES, WHEN?		
_____	_____	23. EAR PAIN IS IT WORSE IN THE ____MORNING ____EVENING ____NEITHER	R	L
_____	_____	24. RECENT DENTAL WORK		
_____	_____	25. DENTURES. AFTER DENTURES? YES ____ NO ____ WHEN WERE THEY ADJUSTED LAST?		
_____	_____	26. TENDENCY TO GRIND YOUR TEETH		
_____	_____	27. DOES ANYONE IN YOUR FAMILY HAVE A HEARING LOSS?		
_____	_____	28. HAS ANYONE IN YOUR FAMILY UNDERGONE SURGERY FOR HEARING?		
_____	_____	29. HAS ANYONE IN YOUR FAMILY BEEN DIAGNOSED WITH OTOSCLEROSIS, HEREDITARY HEARING LOSS OR MENIERE'S DISEASE?		
_____	_____	30. PARENTS, BROTHER OR SISTERS WITH SYPHILIS?		

PLEASE LIST YOUR JOB(S) AND THE LENGTH OF TIME AT EACH, INCLUDING MILITARY EXPERIENCE. PLEASE BE SPECIFIC IN DESCRIBING NOISY JOBS.

1. _____ 2. _____ 3. _____

YES	/	NO	
_____		_____	31. IF YOU HAVE BEEN EXPOSED TO LOUD NOISES, DO YOUR EARS RING OR DO YOU HAVE TEMPORARY HEARING LOSS WHEN YOU LEAVE THE LOUD NOISE?
_____		_____	32. EVEN IF YOU WEAR EAR PROTECTORS?

PLEASE CHECK ANY NOISY RECREATIONAL ACTIVITIES.

YES	NO	
_____	_____	Rifle shooting
_____	_____	Playing in rock and roll bands, classical orchestra, or other musical ensemble
_____	_____	Attending loud music concerts
_____	_____	Listening to music loudly through ear phones or ear inserts
_____	_____	Snowmobiling
_____	_____	Motor cycling
_____	_____	Wood shop or metal shop work
_____	_____	Other. Please list:

YES	NO	
_____	_____	33. DO YOU WEAR EAR PROTECTORS REGULARLY WHEN AROUND LOUD NOISE?

What kind do you use? _____

How long have you been using them? _____

How long were you exposed to such noises before you started using them?

_____

_____	_____	34. DO YOU ALWAYS USE THEM?
_____	_____	35. DO YOU FREQUENTLY SCUBA DIVE?
_____	_____	36. FLY PRIVATE AIRCRAFT OR SKYDRIVE?

YES	NO		RIGHT	LEFT
_____	_____	37. DO YOU HAVE EAR NOISES (TINNITUS)?	R	L Head
		Constant (always there)	R	L
		Intermittent (sometimes there)	R	L
		Fluctuating (variably worse or better)	R	L
		Ringing	R	L
		Buzzing	R	L
		Seashell-like	R	L
		Crickets	R	L
_____	_____	38. DIFFERENT PITCHES IN EACH EAR?		
_____	_____	39. ONLY NOTICEABLE AT NIGHT		
_____	_____	40. VERY DISTURBING		

IF YOUR TINNITUS (EAR NOISE) IS DISTURBING OR GETTING WORSE, PLEASE COMPLETE THE TINNITUS HISTORY FORM.

_____	_____	41. DO YOU HAVE DIZZINESS OR PROBLEMS WITH BALANCE? (IF NO, THE REST OF THIS FORM NEED NOT BE COMPLETED)
_____	_____	42. DIZZINESS (IMBALANCE) WITH RAPID POSITION CHANGES?
_____	_____	43. YOU OR ROOM SPINNING?

_____ _____ 44. LIGHT HEADEDNESS OCCURING WHEN GETTING UP?
_____ _____ 45. FAINT FEELING?
_____ _____ 46. LOSS OF CONSCIOUSNESS?
_____ _____ 47. DIZZINESS FLUCTUATES WITH HEARING FLUCTUATIONS OR TINNITUS?
If Yes, How <u>often</u> does it occur? _____
How <u>long</u> does each episode last? _____

IF DIZZINESS IS A PROBLEM, OCCURS FREQUENTLY, OR INCLUDES A TRUE SENSATION OF MOTION OR SPINNING (AS OPPOSED TO MOMENTARY LIGHT HEADEDNESS), PLEASE COMPLETE THE DIZZINESS HISTORY FORM.