

Name: _____

Date: _____

HEARING LOSS

Duration of Symptoms: _____

Comment _____

Onset: Gradual _____

Comment _____

Sudden _____

Right ear _____

Comment _____

Left ear _____

Both ears _____

Constant _____

Comment _____

Fluctuating _____

Ringing: Right _____

Comment _____

Left _____

Both _____

Balance Disturbance: Vertigo _____

Comment _____

Ataxia _____

Lightheaded _____

Ear: Pressure _____

Right _____

Comment _____

Fullness _____

Left _____

Pain _____

Both _____

NAME:

HISTORY:

Problems with speech:

Skull fracture:

Chemotherapy:

Strong antibiotics for TB, severe bone, lung or abdominal infection:

Recurrent ear infections:

Exposure to loud noises:

work
Military
hunting

Exposure to heavy metals such as lead or mercury:

Medicines for arthritis or malaria:

Hearing loss with mumps, measles or chicken pox:

High fever for an extended time:

Meningitis:

Premature birth: low birth weight: ventilator:
Jaundice at birth requiring bili lights:

Infections with pregnancy or birth:

Family members with hearing loss:
COMMENTS:

Previous ear surgery:
COMMENTS: