Hearing Loss Questionnaire

1. How long have you had hearing loss? _____ days _____ weeks _____ months _____ years
2. Which ear does not hear well? (circle one) left right both
3. Which ear is worse? (circle one) left right both the same
4. Did you hearing loss come on: (circle one) slowly suddenly
5. What caused your hearing loss? _____

	Yes	No
6. Did you ever have a lot of ear infections?		
7. Did you ever have a bad concussion, or other head injury, that caused drainage from you ear or hearing loss?		
8. Were you ever treated for malaria?		
9. Were you ever treated for tuberculosis?		
10. Have you ever been hospitalized and given an antibiotic directly into your veins?		
11. Do you take aspirin, or an aspirin containing medicine, everyday?		
12. Any relatives or family members with hearing loss?		
13. Do you have any ringing or other noises in your ears?		
14. Do you have any dizziness?		
15. Do you work around loud noises?		
16. Did you ever work around loud noises?		
17. Have you ever had any ear surgery?		
18. Do you wear a hearing aid?		
19. Have you ever worn a hearing aid?		
20. Do you have diabetes?		
21. Do you have hypertension?		
20. Do you have thyroid problems?		

Name: _____ Date: _____