

# EAR QUESTIONNAIRE

1. What symptoms are you or your child having? \_\_\_\_\_
2. How many ear infections do you or your child get per year? \_\_\_\_\_
3. What antibiotics have been tried and for how long were they taken? \_\_\_\_\_  
\_\_\_\_\_
4. Which antibiotic works best? \_\_\_\_\_
5. Have you or your child taken preventative antibiotics? \_\_\_\_\_  
Did it work? \_\_\_\_\_
6. What one symptom bothers you most? \_\_\_\_\_
7. Do you think there is a hearing loss? \_\_\_\_\_ Which ear is better? \_\_\_\_\_
8. Are there any balance difficulties? \_\_\_\_\_
9. Do you have any ringing/noises in your ears? \_\_\_\_\_ Which ear? \_\_\_\_\_  
Does the noise sound like a heartbeat? \_\_\_\_\_
10. Has there been any previous ear surgery? \_\_\_\_\_ Which ear? \_\_\_\_\_  
When and Why? \_\_\_\_\_
11. Has there been any noise exposure (ie: firearms, power tools, military)? \_\_\_\_\_
12. Is there any family history of hearing loss? \_\_\_\_\_
13. Have you had any dental work done recently or are you in need of any? \_\_\_\_\_  
\_\_\_\_\_
14. Does your ear have drainage or fluid leaking out of the canal? \_\_\_\_\_
15. Do you experience any feeling of fullness, pressure, or ear pain? \_\_\_\_\_

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Audiologist Signature \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature \_\_\_\_\_ Date: \_\_\_\_\_