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PATIENT HISTORY: HEARING LOSS

NAME: _____ AGE: _____ DATE: _____

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

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

RIGHT / LEFT

R L 1. IN WHICH EAR DO YOU HAVE HEARING LOSS?
R L 2. HOW LONG HAVE YOU HAD A HEARING LOSS? PLEASE DESCRIBE

3. WHO FIRST NOTICED YOUR HEARING LOSS?
You Family Members Others

R L 4. HEARING DECREASE: Slowly
Rapidly
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?

13. ANYTHING MAKE IT BETTER OR WORSE?
DESCRIBE:

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

YES / NO

RIGHT / LEFT

- 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 R L
IS IT WORSE IN THE MORNING EVENING NEITHER
- 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.

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.

- _____ 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 SKYDIVE?
- | | 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)

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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 often does it occur? _____
How long 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.**