

Eisenhower Balance Institute

EAR QUESTIONNAIRE

Date: _____

Patient's Name: _____ DOB: _____

Do you have any of the following (Please check YES or NO):

	RIGHT EAR	LEFT EAR
HEARING LOSS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
PAIN OR ACHE IN EARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
DISCHARGE OR DRAINAGE?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
RINGING, ROARING, OR BUZZING?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
ITCHING?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
NOISE IN YOUR EARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
FULLNESS OR STUFFINESS IN EARS?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Have you ever consulted an ear specialist? YES NO

If YES, When? _____

Have you ever taken large doses of Aspirin-containing products or Quinine? YES NO

Have you ever received injections of Dihydrostreptomycin? YES NO

Have you ever received injections or Kanamycin? YES NO

Have you experienced any of the following (Please check YES or NO):

Double Vision or Blurred Vision?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Constantly?	<input type="checkbox"/> In Episodes?
Blindness?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Constantly?	<input type="checkbox"/> In Episodes?
Numbness of face or extremities?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Constantly?	<input type="checkbox"/> In Episodes?
Difficulty with speech?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Constantly?	<input type="checkbox"/> In Episodes?
Difficulty swallowing?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Constantly?	<input type="checkbox"/> In Episodes?
Tingling around the mouth?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Constantly?	<input type="checkbox"/> In Episodes?
Spots before the eyes?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> Constantly?	<input type="checkbox"/> In Episodes?