Robbinsville/Hamilton: 609-436-5740
Princeton: 609-430-9200
Sewell: 856-589-6673
Voorhees: 856-772-1617

Hearing and Balance Questionnaire

Date ____________________

Patient Name ____ Date of Birth ____________________

Sex ☐ M ☐ F Referring/Family Doctor ______________________________ Tel # ____________________

Chief Complaints:

Please check all reasons below that have brought you to Becker Ear, Nose & Throat:

☐ Hearing Loss ☐ Dizziness ☐ Ringing/Sounds in Ears ☐ Other ______________________________

History of Present Illness:

How long have you had this/these problem(s) and when did they start? ______________________________

Rate your problem's severity on a scale of 1 to 10 ______________________________

What type of treatments/medications have you received for your problem(s)? Have they helped? ____________________

____

Hearing History:

Duration of loss? ______________________________ Sudden or Gradual Onset? ☐ Sudden ☐ Gradual

Which ear? ☐ Right ☐ Left ☐ Both Which ear is used for phone calls? ☐ Right ☐ Left ☐ Both

Tinnitus or noises in ears/head? ☐ Yes ☐ No If yes, describe ____________________

Noise of music exposure (military, work, hobby)? ☐ Yes ☐ No If yes, describe ____________________

Family history of hearing loss? ☐ Yes ☐ No

Ear infections/ear surgery? ☐ Yes ☐ No

Ear pain/drainage? ☐ Yes ☐ No

Ear wax problems? ☐ Yes ☐ No

Dizziness History (complete if patient has dizziness):

When did dizziness begin? ______________________________ Constant or Occasional? ☐ Constant ☐ Occasional

Which term best describes your dizziness? ☐ Spinning ☐ Lightheadedness ☐ Imbalance

Duration each episode? ☐ Seconds ☐ Minutes ☐ Hours ☐ Days

Dizziness worse at a particular time of day? ☐ Yes ☐ No If yes, describe ____________________

Does something in particular bring on the dizziness? ☐ Yes ☐ No If yes, describe ____________________

Can you or anything cause to dizziness the stop/decrease? ☐ Yes ☐ No If yes, describe ____________________

____

Family history of dizziness? ☐ Yes ☐ No If yes, describe ______________________________

Head trauma in the past? ☐ Yes ☐ No If yes, describe ______________________________

Do you get migraines? ☐ Yes ☐ No If yes, for how many years? ______________________________

Do you have motion sensitivity (car, boat, amusement rides)? ______________________________

Do you take medications that could contribute to your dizziness? ☐ Yes ☐ No If yes, describe ____________________

____

Tinnitus (ear noises) History (complete if patient has tinnitus):

Do you have noises in your ears? ☐ Yes ☐ No Which ear is affected? ☐ Right ☐ Left ☐ Both

When did tinnitus begin? ____________________ Can you describe it? ______________________________

Does anything mask (or cover up) the tinnitus? ☐ Yes ☐ No If yes, describe ____________________

Is the noise louder at a particular time of day? ☐ Yes ☐ No When ____________________

Does the noise change pitch or loudness or both? ☐ Yes ☐ No If yes, describe ____________________

Does the tinnitus interfere with daily activities? ☐ Yes ☐ No If yes, describe ____________________

Does the tinnitus interfere with sleep? ☐ Yes ☐ No

Rate annoyance of tinnitus (1 to 10, 1=minimally annoying, 10=excessively annoying) ____________________