Hearing Screening Questionnaire

☐	YES	☐	NO	Had you had draining from your ear in the last 3 months (90 days)?
☐	YES	☐	NO	Had you had rapidly progressing hearing loss in the last 3 months (90 days)?
☐	YES	☐	NO	Had you had sudden hearing loss in the last 90 days?
☐	YES	☐	NO	Had you had a history of any head trauma? When? How?
☐	YES	☐	NO	Had you had a history of ear pain, pressure or fullness recently?
☐	YES	☐	NO	Have you had a history of ear infections?
☐	YES	☐	NO	Have you had a history of any ear surgery? When? Why?
☐	YES	☐	NO	Do you experience frequent dizziness, vertigo, or loss of balance?
☐	YES	☐	NO	Do you have any ringing, buzzing or hissing in your ears?
☐	YES	☐	NO	Do you have a history of noise exposure? (i.e. machine operator)
☐	YES	☐	NO	Do you feel you hear better in one ear than the other?
☐	YES	☐	NO	Have you ever worn a hearing aid? When?
☐	YES	☐	NO	Do you have any deformity / abnormality of the outer ear structure, ear canal, inner ear, or tympanic membrane? What kind?
☐	YES	☐	NO	Do you get significant ear wax accumulation in the external auditory canal / ear?
☐	YES	☐	NO	Do you have a foreign body in the external auditory canal? What kind? Since when?