Ear, Nose and Throat Associates of Northern Colorado

EAR SYMPTOM SHEET

Name: _____ Age:_____ Date:_____

Please answer the following questions carefully.

Why do you come to see the doctor? _____

_____

1. Do you have **ear pain**?	Right / Left / Both / No ear pain
2. Do you have **fullness** or **pressure** your ears?	Yes / No Specify:
3. Do you have **drainage** from your ear/s (other than normal ear wax)?	Right / Left / Both / No Drainage
4. Do you **suspect** any hearing loss?	Yes / No Specify:
5. Did your symptoms begin **suddenly** or **gradually**?	Suddenly / Gradually Specify:
6. Do you have difficulty **understanding** or **communicating** with others?	Yes / No Specify:
7. Do you have **ringing** or **buzzing** in the ears; if so, does it come and go?	Yes / No Specify: Constant / Comes and Goes
8. Have you had **loud noise exposure** in your lifetime; if so, what kind?	Yes / No Specify:
9. Do you suspect that you have taken any **medications** or **antibiotics** that may have affected your hearing?	Yes / No Specify:
10. **Have you** or **do you** currently wear hearing aids?	Yes / No How long:
11. Do you have any **immediate family** with hearing loss?	Yes / No Specify:
12. Do you have dizzy spells?	Yes / No Specify:
13. Have you ever had a **head** or **ear injury**; did they result in a concussion? If so, was there any imaging taken?	Yes / No Specify: CAT Scan / MRI / X-rays Where:
14. Have you ever had an **ear operation**?	Yes / No Specify:
15. Do you or have you been told that you grind your **teeth or have dental** problems?	Yes / No Specify:
16. Did you have ear problems **as a child**?	Yes / No Specify:
17. Have you ever or do you **currently smoke**; how much?	Currently / Former-Quit:_____ / Never / How much:_____
18. Have you had any **recent hearing tests**, if so when and where?	Yes / No When: Where:
ADDITIONAL CONCERNS:	

Ear, Nose and Throat Associates of Northern Colorado

CHILD EAR AND THROAT SYMPTOM SHEET

Name: _____ Age:_____ Date:_____

Please answer the following questions carefully.

What is the reason for your child's visit?_____

_____

1. Has your child had ear infections in the **past year**?	Yes / No If yes, how many?
2. Has your child had **drainage** from their ear/s?	Right / Left / Both / No drainage
3. Has your child been treated with **antibiotics** in the past year?	Yes / No If yes, how many times? What medication?
4. Have you noticed any **hearing loss** in your child?	Yes / No
5. Has your child **failed** a school hearing test?	Yes / No If yes, when?
6. Has your child's physician commented that they have **fluid in** the ear/s?	Yes / No
7. Has your child had two or more episodes of **tonsillitis** in the past year?	Yes / No If yes, how many times?
8. Has your child **missed school** due to current symptoms?	Yes / No If yes, how many?
9. Does your child **mouth breathe** or snore?	Yes / No
10. Does your child **stop breathing** while asleep?	Yes / No
11. Have you been told or do you suspect that your child might have **allergies**?	Yes / No
12. Does your **child** or **any immediate family** have a history of bleeding problems?	Yes / No □ Hemophilia A (factor VIII deficiency) □ Hemophilia B (factor IX deficiency) □ Von Willebrand disease □ Rare factor deficiencies including I, II, V, VII, X, XI, XII and XIII □ Other: _____
ADDITIONAL CONCERNS:	