Hear Sarasota Intake Questionnaire

Date: ____/____/____
Name: ____
Date of Birth: ____/____/____

Referring Physician:

Occupation:

Reason for visit:

Previous Surgeries and Hospitalizations:

Medications (including vitamins, over the counter, herbal, etc.):

HISTORY OF: Abnormal renal function (kidney problems) □ Yes □ No

Hypertension (high blood pressure) □ Yes □ No

Diabetes □ Yes □ No

Allergies □ Yes □ No

Neurological disorder □ Yes □ No

Migraines □ Yes □ No

Cancer □ Yes □ No If yes: Did you undergo chemotherapy or radiation.

Name of chemotherapeutic medication if known: ____________________

Did treatment of cancer affect your hearing: ________________________

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Do you feel you have hearing loss? ☐ Yes ☐ No

If yes: For how long? ____________________

In which ear? ☐ Right ☐ Left ☐ Both

Prior use of hearing aids? ☐ Yes ☐ No

If yes: When? ______________________________

Which ear? ☐ Right ☐ Left ☐ Both

What kind? ___________________________

Were you satisfied with them? ☐ Yes ☐ No

Do you utilize a cochlear implant? ☐ Yes ☐ No

Have you ever had an ear infection or ear surgery? ☐ Yes ☐ No

If yes: When? ____________________________________

Which ear? ☐ Right ☐ Left ☐ Both

Do you ever experience tinnitus (noises/ringing in the ears)? ☐ Yes ☐ No

If yes: For how long? ______________________

In which ear? ☐ Right ☐ Left ☐ Both

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Are the noises constant or intermittent? □ Constant □ Intermittent

Please describe the noise as best you can:

____

____

____

Do you ever experience dizziness or imbalance? □ Yes □ No

If yes: When was the onset?

____

How many episodes?

____

Any vomiting/nausea?

____

Please describe the dizziness:

____

____

____

____

Have you ever been exposed to loud noise? □ Yes □ No For how long?

____

If yes: Indicate what type of noise you were exposed to:

Industrial noise: □ Yes □ No

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Agricultural Noise: ☐ Yes ☐ No

Loud Engines: ☐ Yes ☐ No

Firearms: ☐ Yes ☐ No

If yes: Do you use protection while shooting? ☐ Yes ☐ No

Loud Music: ☐ Yes ☐ No

Describe any other loud noise you may have been exposed to:

____

____

____

Did you wear ear protection during noise exposure? ☐ Yes ☐ No

Indicate when you wore ear protection: ______________________________

Have you ever had a head injury? ☐ Yes ☐ No

If yes: Was there any loss of consciousness or concussion? ☐ Yes ☐ No

Do you have hearing loss in your family? ☐ Yes ☐ No

If yes: Which family member?

____

Cause of hearing loss (if known)?

____

Hear Sarasota Intake Questionnaire

Did the familial hearing loss originate congenitally/ at birth?