MINNEAPOLIS OTOLARYNGOLOGY
TINNITUS & RINGING IN EARS INFORMATION SHEET

NAME:_________________________________ **DATE:**______________________

1. Chief Complaint: What is it that bothers you most about your ears and hearing?

2. Do you have ringing or any other noises in your ears?_____ If yes, please describe. Is there anything that makes these noises louder?

Is there anything that helps relieve these noises?

3. Do you have significant episodes of imbalance or dizziness?_____ If yes, please describe.

4. Work history:

Name of Company	Years Worked	Type of Noise Exposure	Hearing Protection
			Yes___No___

5. Other work history (farming, construction, etc.)

6. Other noise exposure:

Hobbies (power tools, guns, snowmobiles, motorcycles, chainsaws, etc.)

Do you use hearing protection during these activities? ________

7. Military Service: Please give dates and types of noise exposure.
19___ to ____________

Did you use hearing protection?_______

(OVER)

8. Caffeine Intake: (Coffee, soda, etc.) # of cups/cans per day ________.

9. History of smoking: Number of years________ Packs per day _______.

10. Alcohol intake: Circle one ---- Daily Weekly Occasionally None

11. History of significant medical illnesses in the past:

12. Present medical conditions and medications taken:

13. Is there any history of hearing loss in your family? (Parents, Siblings)
If so, who? At what age?
a.
b
c

14. Do you know of any specific instances or events in the past, which adversely affected your hearing?

15. Any other comments?