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OMB#: 0925-0584
Exp. 2/28/2011

HCHS/SOL Hearing Exam Questionnaire

ID NUMBER:

FORM CODE: HEE
VERSION: A 8/23/07

Contact Occasion

SEQ #

Acrostic: _____

ADMINISTRATIVE INFORMATION

0a. Completion Date: / /
Month Day Year

0b. Staff ID:

Instructions: Enter the answer given by the participant for each response. The special value, "Q", is allowed for cases where the response 'Don't know/refused' is not listed as an option. These questions must be asked *before* the hearing examination begins.

A. Self Assessed Hearing Loss

- Do you feel you have a hearing loss?

No	0	<input type="checkbox"/>	→	GO TO QUESTION 5
Yes	1	<input type="checkbox"/>		
Don't know/refused	9	<input type="checkbox"/>	→	GO TO QUESTION 5
- Which is your better ear?

Left	1	<input type="checkbox"/>
Right	2	<input type="checkbox"/>
No difference	3	<input type="checkbox"/>
Don't know/refused	9	<input type="checkbox"/>
- Was your hearing loss sudden or gradual?

Sudden	1	<input type="checkbox"/>
Gradual	2	<input type="checkbox"/>
Don't know/refused	9	<input type="checkbox"/>
- How old were you when your hearing loss developed?

Less than 5 years old	1	<input type="checkbox"/>
5 to 19 years	2	<input type="checkbox"/>
20 to 29 years	3	<input type="checkbox"/>
30 to 39 years	4	<input type="checkbox"/>
40 to 49 years	5	<input type="checkbox"/>
50 to 59 years	6	<input type="checkbox"/>
60 to 69 years	7	<input type="checkbox"/>
70 years or more	8	<input type="checkbox"/>
Don't know/refused	9	<input type="checkbox"/>

B. Tinnitus

- In the past year have you had buzzing, ringing, or noise in your ears?

No	0	<input type="checkbox"/>	→	GO TO QUESTION 10
Yes	1	<input type="checkbox"/>		
Don't know/refused	9	<input type="checkbox"/>	→	GO TO QUESTION 10
- Does this noise usually last longer than 5 minutes?

No	0	<input type="checkbox"/>	Yes	1	<input type="checkbox"/>	Don't know/refused	9	<input type="checkbox"/>
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7. Do you hear this noise only following very loud sounds (i.e. concerts, shooting, or noise at work)?
 No 0 Yes 1 Don't know/refused 9

8. Does this noise cause you to have problems getting to sleep?
 No 0 Yes 1 Don't know/refused 9

9. In the past 12 months, how often have you had this ringing, roaring, or buzzing in your ears or head?
 Almost always 1
 At least once a day 2
 At least once a week 3
 At least once a month 4
 Less than once a month 5
 Don't know/refused 9

C. Hearing Medical History

10. When was the last time you saw a doctor or other health care professional about any hearing or ear problems?

Never 0
 Past year 1
 1 to 2 years 2
 3 to 4 years 3
 5 to 9 years 4
 10 to 14 years 5
 15 years or more 6
 Don't know/refused 9

11. When was the last time you had your hearing tested?

Never 0
 Past year 1
 1 to 2 years 2
 3 to 4 years 3
 5 to 9 years 4
 10 to 14 years 5
 15 years or more 6
 Don't know/refused 9

12. Have you ever had surgery on your ears?

No 0 → **GO TO QUESTION 14**
 Yes 1
 Don't know/refused 9 → **GO TO QUESTION 14**

13. What type of surgery was done?

Tympanoplasty 1
 Mastoidectomy 2
 Stapedectomy 3
 Cochlear implant 4
 Other 5

