

Results?

Have you ever seen an Ear, Nose, & Throat doctor? Yes No

Name: _____
Chart #: _____

Have you ever had ear surgery? Yes No

Do you suspect a hearing loss? Yes No

If YES, was it: Gradual Sudden Fluctuating (comes & goes)

List anyone in your family who has hearing loss:

Have you been exposed to loud noises? (gunfire, machinery, military, etc.)

Do you hear noises in your head or ears? Yes No

If YES, describe:

Do you have a feeling of pain, pressure, or discomfort in your ears? Yes No

Do you have any of these medical problems with your eyes/vision?

- Double vision Spots before eyes Lazy or wandering eye
 Blurred vision Cataracts Glasses or contacts

Please list all physicians that you would like informed of your WTRC results?