Eyes/Ears Questionnaire

Name **Date**

INSTRUCTIONS: Please circle the number which best describes the frequency or severity of your complaints. Leave the question blank if it does not apply to you.
0 = RARELY OR NEVER EXPERIENCE SYMPTOM 1 = MILD 2 = MODERATE 3 = SEVERE

PART 1: Eye and Ear Function

Section A:

1	Experience any visual problems	0 1 2 3
2	Night blindness	0 1 2 3
3	Cloudy vision	0 1 2 3
4	Discharge from your eyes	0 1 2 3
5	Pain, swelling or redness of your eyes	0 1 2 3
6	Diagnosed with any eye disorder (Press 0 for NO, 1 for YES)	NO YES
7	If yes to Question 6, what is the disorder: Cataract___Glaucoma___Macular Degeneration___Other_____	

Section B:

1	General ear pain	0 1 2 3
2	Earache	0 1 2 3
3	Red, swollen eardrum	0 1 2 3
4	Dull, throbbing pain in ear	0 1 2 3
5	Ringing in ears	0 1 2 3
6	Static sounds in ears	0 1 2 3
7	Current ear infection (Press 0 for NO, 1 for YES)	NO YES