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Ear Pressure / Fullness / Eustachian Tube Dysfunction Questionnaire

PATIENT NAME: _____ DATE: _____

Over the past 1 month, how much has each of the following been a problem for you?

	No Problem	Mild	Moderate	Severe		
1. Pressure in the ears?	0	1	2	3	4	5
2. Pain in the ears?	0	1	2	3	4	5
3. A feeling that your ears are clogged or “under water”?	0	1	2	3	4	5
4. Ear symptoms when you have a cold or sinusitis?	0	1	2	3	4	5
5. Crackling or popping sounds in the ears?	0	1	2	3	4	5
6. Ringing in the ears?	0	1	2	3	4	5
7. A feeling that your hearing is muffled?	0	1	2	3	4	5
8. Hearing loss?	0	1	2	3	4	5