

This questionnaire is designed to help you decide if you need to see a doctor before obtaining a hearing device. If you have any medical questions or concerns about your hearing, you should see a doctor no matter what your score is on this questionnaire.

Questions about your Ears and Hearing

Circle “Yes” or “No”

1. When talking on a telephone, do you understand what people say better in one ear than the other?	Yes	No
2. Did the hearing loss in either of your ears develop suddenly?	Yes	No
3. Have you ever had a sudden permanent change in your hearing?	Yes	No
4. Do you have hearing loss in only one ear?	Yes	No
5. Do you hear better in one ear than the other?	Yes	No
6. Does your hearing change from day to day?	Yes	No
7. As an adult, have you ever had more than one infection in the same ear during one year?	Yes	No
8. Have you ever noticed pus, blood or other active fluid discharge from your ear?	Yes	No
9. Have you ever been told by a physician that you have Meniere’s disease?	Yes	No

10. Overall, how would you rate your health?

- Very good
- Good
- Poor
- Very poor

11. How often do you have dizziness?

- Never
- Occasionally
- Frequently
- Always

12. How would you rate your balance?

- Very good
- Good
- Poor
- Very poor

13. Do you have tinnitus, such as ringing, roaring, or cricket-like sounds in your ears?

Yes	No
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If you answered “No”, skip to question 14.

13a. If yes to 13, do you have tinnitus in (check one):

- Right Ear
- Left Ear
- Both Ears
- Unsure

13b. If yes to 13a, do you have any of the following symptoms with your tinnitus?

Dizziness	Yes	No
Pressure in the ear	Yes	No
Fullness in the ear	Yes	No
Plugged feeling in the ear	Yes	No

14. Have you ever had any of the following symptoms lasting longer than 10 minutes?

Sudden drop in hearing in one or both ears	Yes	No
A rapid change in vision in one or both eyes	Yes	No

15. In the past 3 months, have you had any of the following symptoms?

Any persistent discharge from either ear	Yes	No
Pus or blood in your ears	Yes	No
Any persistent pain in or around either ear	Yes	No
A change in hearing in one or both ears	Yes	No
A head cold or sinus problem that made your hearing worse	Yes	No
Dizziness	Yes	No
Fell because of poor balance	Yes	No
A persistent or recurring headache	Yes	No
Recurring fever, night sweats, chills	Yes	No

Score Sheet

Please proceed with scoring only if you have finished answering all questions on pages 1 and 2. Check on pages 1 and 2 to ensure you have answered all 15 questions before you calculate your score.

For the following questions count the number of times you have responded “yes”:

Question #	1	2	3	4	5	6	7	8	9
Number of “yes”									
	<i>Add the numbers in the boxes above [A]</i>								

Question #		Points
10	One point if “Poor” or “Very Poor” is checked	
11	One point if “Frequently” or “Always” is checked	
12	One point if “Poor” or “Very Poor” is checked	
13	No points for this question.	0
13a	One point if either “Right ear” OR “Left Ear” is checked, Zero if both are checked	
13b	Number of “yes” responses	
14	Number of “yes” responses	
15	Number of “yes” responses	
	<i>Add points above [B]</i>	

Add scores from above: A + B = CEDRA score

If your score is 4 or higher, you should talk to a doctor about your symptoms.