Vijay K. Anand, M.D., F.A.C.S.
772 Park Avenue, New York, NY 10021
Tel: (212) 452-3005 Fax: (212) 452-3660

ETD Questionnaire

Patient Name:_____ Date:_____

1. During the past 1 Month, how much of a problem was each of the following?

	No Problem			Moderate Problem			Severe Problem
1. Pressure in the ears?	1	2	3	4	5	6	7
2. Pain in the ears?	1	2	3	4	5	6	7
3. A feeling that your ears are clogged or "under water"?	1	2	3	4	5	6	7
4. Ear problems when you have a cold or sinusitis?	1	2	3	4	5	6	7
5. Cracking or popping sounds in the ears?	1	2	3	4	5	6	7
6. Ringing in the ears?	1	2	3	4	5	6	7
7. A feeling that your hearing is muffled?	1	2	3	4	5	6	7

2. Did you get these symptoms in one ear only or both ears?

____ Both ears

____ One ear only