Oregon Ear, Nose and Throat Center

# Eustachian Tube Dysfunction Questionnaire

Print Name: _____ Date of Birth: _____ Date: _____

**Please circle the number to the right of each question that best describes how you feel.**

| **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.** | 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.** | Crackling 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.** | Feeling that your hearing is muffled? | 1 | 2 | 3 | 4 | 5 | 6 | 7 |

Are these symptoms in one ear only or both ears? ☐ Left ear only ☐ Right ear only ☐ Both ears

Total Score _____ Divided by 7 = Mean item score _____