

Veteran's Full Name: _____

Veteran's Date of Birth: _____ Today's Date: _____

The following information is needed in order to draft the Nexus Letter for the Veteran Affairs. Please be thorough in your descriptions. Please include dates and describe the event in as much detail as possible.

Military History:

What branch of the military did you serve? _____

What were your roles in the military? What was your military occupational specialty (MOS)? _____

What were your dates of service? _____

Hearing History:

When did you first notice difficulty hearing? _____

Was there an event that occurred during service that started your difficulty with hearing? If yes, describe the event?

How would you best describe your hearing?

- Hearing is fine with no concerns
- Difficulty hearing in noisy environments
- Difficulty hearing in group situations
- Able to hear but not clearly
- Difficulty hearing from a distance
- Unable to hear

Do you feel that your hearing is better in one ear versus the other?

- Both ears are about the same
- My right ear is better
- My left ear is better

Have hearing aids been recommended to you?

- Yes No

If yes, do you wear them and in what ear?

- Both ears
- Right ear only
- Left ear only
- I do not wear hearing aids

Is there a history of hearing loss in your family? Yes No

Who has hearing loss? Do you know the cause of their hearing loss?

Medical History:

Do you have a history of ear problems, medically? Please check all that apply:

- Ear pain
- Ear Infections (date of most recent: _____)
- Fullness or pressure in ears
- Dizziness
- History of ear surgery (date of surgery: _____)

Have you ever been diagnosed with and/or received any of the following?

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Osteosclerosis | <input type="checkbox"/> Acoustic neuroma | <input type="checkbox"/> Cholesteatoma | <input type="checkbox"/> Labyrinthitis |
| <input type="checkbox"/> Meningitis | <input type="checkbox"/> Meniere's disease | <input type="checkbox"/> Measles | <input type="checkbox"/> Permanent hearing loss |
| <input type="checkbox"/> Bell's palsy | <input type="checkbox"/> Radiation/Chemotherapy | <input type="checkbox"/> Cancer | <input type="checkbox"/> Ossicular dislocation/fixation |
| <input type="checkbox"/> Barotrauma | <input type="checkbox"/> Sudden hearing loss | <input type="checkbox"/> Head trauma | <input type="checkbox"/> Long term IV antibiotics |
| <input type="checkbox"/> None of these apply to me | | | |

Please provide details regarding the boxes checked above. Please include dates of diagnosis.

Tinnitus History

Do you have ringing in your ears? Yes No If yes, what date did it begin? _____

Is it in both ears? Right ear only Left ear only Both ears

Is the ringing constant or does it come and go? Constant Intermittent

Can you remember an event during your service when the tinnitus began? Please describe the event.

History of Noise Exposure

What noise exposure did you have prior to your service in the military?

Did you use hearing protection during this time? Yes No

Please describe any noise exposure during service.

Please describe noise exposure following your service in the military.

Have you had any recent exposure to any loud noise post-service? Check all that apply.

- | | | | |
|--------------------------------------|--|---|--|
| <input type="checkbox"/> Firearms | <input type="checkbox"/> Aircraft noise | <input type="checkbox"/> Farm equipment | <input type="checkbox"/> Heavy equipment |
| <input type="checkbox"/> Power tools | <input type="checkbox"/> Motorcycles/recreational vehicles | <input type="checkbox"/> Other: _____ | |

Did you use hearing protection during this time? Yes No

Veteran's signature: _____

Date this form was completed and signed: _____

Thank you for your service!