

Nursing Ear Assessment

Patient information	
Name:	Gender:
Date of birth:	Medical ID:
Date of assessment:	Assessed by:
Allergies:	
Current medications:	
Patient history	
Previous ear surgeries or known ear or hearing conditions:	History of ear infections:
Hearing loss history:	Exposure to loud noise (85 decibels or more):
Use of hearing aids:	Family history of ear diseases/conditions or premature hearing loss:
<input type="checkbox"/> Yes (currently uses) <input type="checkbox"/> No	
Recent upper respiratory infections:	Other relevant history:

General observations	
Signs of distress or discomfort:	
<input type="checkbox"/> Yes <input type="checkbox"/> No	
Patients ability to follow instructions:	<i>If impaired, please describe:</i>
<input type="checkbox"/> Good <input type="checkbox"/> Impaired <input type="checkbox"/> N/A	
Ear pain assessment	
Ear pain:	<i>If pain is present, please describe:</i>
<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Severe	
Pain onset:	Pain duration:
Factors aggravating pain:	Factors relieving pain:
Associated symptoms:	
External ear inspection (please indicate on which are any abnormalities are found)	
Skin integrity:	Presence of erythema:
<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal <input type="checkbox"/> Not assessed	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not assessed
<i>If abnormal, describe:</i>	<i>If present, describe:</i>

Lesions or lumps:	Swelling:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Not assessed	<input type="checkbox"/> Not assessed
<i>If present, describe:</i>	<i>If abnormal, describe:</i>
Drainage:	Cerumen accumulation:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Not assessed	<input type="checkbox"/> Not assessed
<i>If abnormal, describe:</i>	<i>If abnormal, describe:</i>
Post auricular area:	Mastoid process:
<input type="checkbox"/> Normal	<input type="checkbox"/> Normal
<input type="checkbox"/> Abnormal	<input type="checkbox"/> Abnormal
<input type="checkbox"/> Not assessed	<input type="checkbox"/> Not assessed
<i>If abnormal, describe:</i>	<i>If abnormal, describe:</i>

Palpation of external ear	
Tenderness:	Mass palpable:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Not assessed	<input type="checkbox"/> Not assessed
<i>Location and pain description:</i>	<i>Details:</i>
Warmth:	Crepitus:
<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
<input type="checkbox"/> No	<input type="checkbox"/> No
<input type="checkbox"/> Not assessed	<input type="checkbox"/> Not assessed
<i>Details:</i>	<i>Details:</i>
Other external abnormalities:	
Otoscopic examination	
Right ear external canal:	<i>Details:</i>
<input type="checkbox"/> Normal	
<input type="checkbox"/> Abnormal	
<input type="checkbox"/> Not assessed	

Right ear tympanic membrane appearance & color:	
Right ear tympanic membrane mobility:	
Right ear scarring or perforation:	Details:
<input type="checkbox"/> Present <input type="checkbox"/> Not present <input type="checkbox"/> Not assessed	
Right ear fluid or pus:	Details:
<input type="checkbox"/> Present <input type="checkbox"/> Not present <input type="checkbox"/> Not assessed	
Left ear external canal:	Details:
<input type="checkbox"/> Present <input type="checkbox"/> Not present <input type="checkbox"/> Not assessed	
Left ear tympanic membrane appearance and color:	
Left ear tympanic membrane mobility:	

Left ear scarring or perforation:	<i>Details:</i>
<input type="checkbox"/> Present <input type="checkbox"/> Not present <input type="checkbox"/> Not assessed	
Left ear fluid or pus:	<i>Details:</i>
<input type="checkbox"/> Present <input type="checkbox"/> Not present <input type="checkbox"/> Not assessed	
Hearing assessment	
Audiometry test results:	
Whisper test results:	
<i>In:</i>	
<input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> Both ears	
Weber test results:	
<input type="checkbox"/> Lateralization to right ear <input type="checkbox"/> Lateralization to the left ear <input type="checkbox"/> None <input type="checkbox"/> N/A	
Right ear Rinne test:	<i>Details:</i>
<input type="checkbox"/> AC > BC <input type="checkbox"/> BC > AC <input type="checkbox"/> N/A	
Left ear Rinne test:	<i>Details:</i>
<input type="checkbox"/> AC > BC <input type="checkbox"/> BC > AC <input type="checkbox"/> N/A	

Other hearing tests:

Patient's self assessment of hearing:

Additional observations and comments:

Nurse signature: _____

Nurse name: _____ **Date:** _____

Note: This document is intended as a guidance tool for healthcare professionals only. It should be used in accordance with hospital policies and procedures. All assessments must be carried out by a qualified nurse or healthcare provider.