Audiology Questionnaire

Name: ____ Date______________

How did you learn about our office? ____

Which of the following concerns brings you to our office?

1. **Difficulty hearing**
   a. How long have you had this problem? _________ ***days / weeks / months / years***

   b. Has a hearing problem con on ***gradually*** or rather ***suddenly***?

   c. Do you hear better with one ear?

   Better right ***Better left*** ***Same in both***

   d. Please circle all of the following hearing/understanding difficulties that apply:

   Difficulty hearing spouse ***Difficulty hearing children/family/friends***
   Difficulty hearing TV ***Difficulty hearing on the telephone***
   Difficulty hearing at work ***Difficulty hearing religious service***
   Difficulty hearing in restaurants ***Difficulty hearing in small groups***
   Other____

   e. Do you think you need help to hear better? ***Yes*** ***No***

2. **Noises/Ringing/Buzzing/Humming in the ear(s)/ Tinnitus**
   a. How long have you had this problem? __________ ***days / weeks / months / years***

   b. Is the noise more prominent in one ear?
   More in right ear ***Same in both ears***
   More in left ear ***Middle of head***

   c. Is the noise ***constant*** (always present) or intermittent (comes and goes)?

   d. Is the tinnitus ***manageable***, or very ***disruptive*** to your life?

3. **Dizziness/Lightheadedness/Vertigo (spinning sensation)**
   a. How long have you had this problem? __________ ***days / weeks / months / years***

   b. Please describe the balance disturbance:____

   ____

4. **Please circle Y (yes) or N (no) for each symptom below:**

Y N Ear pain/infections/drainage
Y N Ear Fullness
Y N Sudden or rapidly progressive hearing loss in the last 90 days
Y N Ear surgery

Y N Allergies

Y N Hospitalization for serious illness
Y N Cancer of the head or neck
Y N Radiation of the head or neck

Y N Stroke
Y N Parkinson's disease
Y N Memory problems

Y N Vision deficits

Y N Diabetes

Y N Heart disease

Y N Arthritis
Y N Difficulty with manual dexterity

Y N History of loud noise exposure
Y N History of exposure to chemicals

Y N Family history of hearing loss

Y N History of hearing aid use

5. Please indicate your current medications (or provide a list that our office may photocopy):

____

____

6. Please describe any other hearing, ear, nose, or throat problem which causes you concern:

____

____

Patient Signature: ____ Date: ________________

Provider Signature: ____ Date: ________________