

**Western Washington Medical Group  
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 come 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 TV*

*Difficulty hearing at work*

*Difficulty hearing in restaurants*

*Other* \_\_\_\_\_

*Difficulty hearing children/family/friends*

*Difficulty hearing on the telephone*

*Difficulty hearing religious service*

*Difficulty hearing in small groups*

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*

*More in left ear*

*Same in both ears*

*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.    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

4. Please indicate your current medications:

---



---

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

---



---

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Provider Signature: \_\_\_\_\_ Date: \_\_\_\_\_