WEST COAST HEARING CLINIC
You should HEAR what you're missing!

Adult History Audiological Re-Evaluation Questionnaire

Name: _____ Date: _____

Primary Care Physician: _____

Referring Physician: _____

1. Have we seen you at this office before? ☐ Yes ☐ No

2. Describe the problem or reason for this evaluation: _____

   _____

3. Has hearing decreased since your previous evaluation? ☐ Yes ☐ No

4. Please answer the questions below:
   a. Was the onset and progression of your hearing loss: ☐ Sudden ☐ Gradual
   b. Do you hear better in one ear than the other? ☐ Yes ☐ No
      If YES, in which ear do you hear better? ☐ Right ☐ Left
   c. Does your hearing seem to fluctuate? ☐ Yes ☐ No
   d. Do you feel your hearing has changed? ☐ Yes ☐ No
      If YES: ☐ Gradual ☐ Sudden ☐ Fluctuates
   e. Do you experience any dizziness or vertigo? ☐ Yes ☐ No
   f. Do you experience any tinnitus? ☐ Yes ☐ No
   g. Can you hear but have problems understanding? ☐ Yes ☐ No
   h. Do you have any family members that had hearing loss before age 50? ☐ Yes ☐ No
   Relationship: _____

5. History of medical conditions related to your hearing:
   Do you have any of the following symptoms:
   a. Ear pain? ☐ Yes ☐ No ☐ Right ☐ Left
   b. Do you experience pressure in your ears? ☐ Yes ☐ No ☐ Right ☐ Left
   c. Perforation of the eardrum? ☐ Yes ☐ No ☐ Right ☐ Left
   d. Soreness in the canal? ☐ Yes ☐ No ☐ Right ☐ Left
   e. Laceration of the ear? ☐ Yes ☐ No ☐ Right ☐ Left
   f. Trauma to the ear? ☐ Yes ☐ No ☐ Right ☐ Left
   g. Have you had any recent ear infections or drainage? ☐ Yes ☐ No
      If YES, please answer the question below:
      Please indicate as an/a ☐ Adult ☐ Child ☐ Both
      Last infection date? _____
   h. PE tubes? ☐ Yes ☐ No
      When: _____ Surgeon: _____
   i. Ear surgeries? ☐ Yes ☐ No
      When: _____ Surgeon: _____

Turn over

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6. History of medical conditions: (Check all that apply)

- ☐ Acoustical trauma
- ☐ Allergies
- ☐ Arthritis
- ☐ Blurred vision
- ☐ Cancer
- ☐ Cholesterol
- ☐ Diabetes
- ☐ Disease accompanied by high fever
- ☐ Headaches
- ☐ High blood pressure
- ☐ Heart/Cardiac problems
- ☐ Severe blow to the head
- ☐ Sinus problems
- ☐ Stroke

7. Do you have hearing difficulty with: (Check all that apply)

- ☐ One-to-one conversations
- ☐ Women's voices
- ☐ Children's voices
- ☐ Telephone conversations
- ☐ Small group conversations
- ☐ Large group conversations
- ☐ Group of people with multiple talkers
- ☐ Presence of background noise
- ☐ Concerts or plays
- ☐ TV volume turned up
- ☐ Movies
- ☐ Other _____

8. Have you previously seen an audiologist or had your hearing tested? ☐ Yes ☐ No

When? _____

Name of audiologist or organization: _____

Please check "yes," "sometimes" or "no" for each of the following items. Do not skip a question if you avoid a situation because of a hearing problem. If you use a hearing aid, please answer the way you hear without the aid.

	Questions	**Yes**	**Sometimes**	**No**
E1	Does a hearing problem cause you to feel embarrassed when you meet new people?			
E2	Does a hearing problem cause you to feel frustrated when talking to members of your family?			
E3	Do you have difficulty hearing when someone speaks in a whisper?			
E4	Do you feel handicapped by a hearing problem?			
E5	Does a hearing problem cause you difficulty when visiting friends, relatives or neighbors?			
E6	Does a hearing problem cause you to attend religious services less often than you would like?			
E7	Does a hearing problem cause you to have arguments with family members?			
E8	Does a hearing problem cause you difficulty when listening to the radio or television?			
E9	Do you feel that any hearing difficulty limits or hampers your personal or social life?			
E10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends?			

Clinic use only

Total Score: _____ / 40

Social Score: _____ / 20

Emotional Score: _____ / 20

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Name: _____

9. Do you experience tinnitus (ringing, buzzing or roaring) in your ears? ☐ Yes ☐ No

10. Has your tinnitus increased since your last evaluation? ☐ Yes ☐ No

If YES, please answer the questions below and **complete the tinnitus questionnaires.**

a. Which ear(s) do you experience tinnitus? ☐ Right ☐ Left ☐ Both
b. Is it bothersome? ☐ Yes ☐ No
c. Any sleep issues due to tinnitus? ☐ Yes ☐ No
d. How long have you experienced tinnitus? _____
e. Do you notice tinnitus in quiet situations? ☐ Yes ☐ No
f. Do you notice tinnitus in noisy situations? ☐ Yes ☐ No
g. Is your tinnitus? ☐ High pitched ☐ Low pitched
h. Is your tinnitus? ☐ Single noise ☐ Multiple sounds
i. Is your tinnitus? ☐ Pulsation ☐ Rhythmic quality ☐ Steady
j. Is your tinnitus? ☐ Constant ☐ Intermittent
k. If intermittent, how often and how long does it last? _____

11. Have you ever experienced dizziness, unsteadiness, imbalance, equilibrium difficulties or vertigo? ☐ Yes ☐ No

If YES, please answer the questions below and **complete the dizziness questionnaire.**

a. Do you experience balance difficulty? ☐ Yes ☐ No
b. Do you experience lightheadedness? ☐ Yes ☐ No
c. Do you experience spinning sensations? ☐ Yes ☐ No
   How long have you experienced these symptoms? _____
d. Do you feel dizzy today? ☐ Yes ☐ No
e. Have you fallen in the past 12 months? ☐ Yes ☐ No
f. How many times? _____
g. Have you been injured? ☐ Yes ☐ No

Describe: _____

12. Have you ever worn hearing aids? ☐ Yes ☐ No

If YES, please answer the questions below:

a. Which ear was fit with hearing aids? ☐ Right ☐ Left ☐ Both
b. How long have you used hearing aids? _____
c. Where and when did you purchase your current hearing aids? _____
d. What would you like to improve with hearing aids? _____

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Name: _____

13. Have you had any loud noise exposure either recently or in the past? ☐ Yes ☐ No

If YES, please answer the questions below:

☐ Farm equipment ☐ Power tools ☐ Music ☐ Hunting/Shooting ☐ Motorcycles/ATV
☐ Jet engines ☐ Factory noise ☐ Military ☐ Occupational ☐ Other _____

a. Number of years exposed to noise: _____
b. Job Title/Description: _____
c. Employer at the time of noise exposure: _____
   ☐ Currently employed
   ☐ Not currently employed
   Date of retirement or termination of employment: _____
d. Were hearing protection devices utilized? ☐ Yes ☐ No
e. How often is/was hearing protection used? _____

14. Tobacco Use

a. Have you ever used tobacco products? ☐ Yes ☐ No
b. Do you currently use tobacco products? ☐ Yes ☐ No
c. If YES, please answer the questions below:
   ☐ Cigarettes ☐ Smokeless ☐ Cigars ☐ E-Cigs ☐ Other
   How often? _____
a. Do you currently use recreational drugs? ☐ Yes ☐ No
   If yes, have you used any recreational drugs in the past 24 hours? ☐ Yes ☐ No

15. Social

a. Do you feel safe at home? ☐ Yes ☐ No
b. Has anyone limited your daily activities? ☐ Yes ☐ No
c. Has someone talked to you in a threatening way? ☐ Yes ☐ No
d. Has anyone tried to force you to give them money or sign strange papers? ☐ Yes ☐ No
e. Has anyone touched you without your consent or hit you? ☐ Yes ☐ No

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INTERNATIONAL OUTCOME INVENTORY FOR HEARING AIDS (IOI-HA)

(Please complete if you use hearing aids.)

Name: _____ Date: _____

1. Think about how much you used your present hearing aid(s) over the past two weeks.
   On an average day, how many hours did you use the hearing aid(s)
   ☐ None ☐ Less than 1 hour a day ☐ 1 to 4 hours a day ☐ 4 to 8 hours a day ☐ More than 8 hours a day

2. Think about the situation where you most wanted to hear better, before you got your present hearing aid(s).
   Over the past two weeks, how much has the hearing aid helped in that situation?
   ☐ Helped not at all ☐ Helped slightly ☐ Helped moderately ☐ Helped quite a lot ☐ Helped very much

3. Think again about the situation where you most wanted to hear better.
   When you use your present hearing aid(s), how much difficulty do you STILL have in that situation?
   ☐ Very much difficulty ☐ Quite a lot of difficulty ☐ Moderate difficulty ☐ Slight difficulty ☐ No difficulty

4. Considering everything, do you think your present hearing aid(s) is worth the trouble?
   ☐ Not at all worth it ☐ Slightly worth it ☐ Moderately worth it ☐ Quite a lot worth it ☐ Very much worth it

5. Over the past two weeks, with your present hearing aid(s), how much have your hearing difficulties affected the things you can do?
   ☐ Affected very much ☐ Affected quite a lot ☐ Affected moderately ☐ Affected slightly ☐ Affected not at all

6. Over the past two weeks, with your present hearing aid(s), how much do you think other people were bothered by your hearing difficulties?
   ☐ Bothered very much ☐ Bothered quite a lot ☐ Bothered moderately ☐ Bothered slightly ☐ Bothered not at all

7. Considering everything, how much has your present hearing aid(s) changed your enjoyment of life?
   ☐ Worse ☐ No change ☐ Slightly better ☐ Quite a lot better ☐ Very much better

8. How much hearing difficulty do you have when you are **not** wearing a hearing aid?
   ☐ Severe ☐ Moderately-severe ☐ Moderate ☐ Mild ☐ None

WEST COAST HEARING CLINIC
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Tinnitus Handicap Inventory *(Only complete if you have tinnitus or ringing in the ears.)*

Patient Name: _____ Date: _____

The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1.	Because of your tinnitus, is it difficult for you to concentrate?	☐ Yes	☐ Sometimes	☐ No
2.	Does the loudness of your tinnitus make it difficult for you to hear people?	☐ Yes	☐ Sometimes	☐ No
3.	Does your tinnitus make you angry?	☐ Yes	☐ Sometimes	☐ No
4.	Does your tinnitus make you feel confused?	☐ Yes	☐ Sometimes	☐ No
5.	Because of your tinnitus, do you feel desperate?	☐ Yes	☐ Sometimes	☐ No
6.	Do you complain a great deal about your tinnitus?	☐ Yes	☐ Sometimes	☐ No
7.	Because of your tinnitus, do you have trouble falling asleep at night?	☐ Yes	☐ Sometimes	☐ No
8.	Do you feel as though you cannot escape your tinnitus?	☐ Yes	☐ Sometimes	☐ No
9.	Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner or to the movies)?	☐ Yes	☐ Sometimes	☐ No
10.	Because of your tinnitus, do you feel frustrated?	☐ Yes	☐ Sometimes	☐ No
11.	Because of your tinnitus, do you feel that you have a terrible disease?	☐ Yes	☐ Sometimes	☐ No
12.	Does your tinnitus make it difficult for you to enjoy life?	☐ Yes	☐ Sometimes	☐ No
13.	Does your tinnitus interfere with your job or household responsibilities?	☐ Yes	☐ Sometimes	☐ No
14.	Because of your tinnitus, do you find that you are often irritable?	☐ Yes	☐ Sometimes	☐ No
15.	Because of your tinnitus, is it difficult for you to read?	☐ Yes	☐ Sometimes	☐ No
16.	Does your tinnitus make you upset?	☐ Yes	☐ Sometimes	☐ No
17.	Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	☐ Yes	☐ Sometimes	☐ No
18.	Do you find it difficult to focus your attention away from your tinnitus and on other things?	☐ Yes	☐ Sometimes	☐ No

For Office Use Only

Total Per Column	☐		☐		☐			
	x4		x2		x0			
Total Score	☐	+	☐	+	☐	=	☐	

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Patient Health Questionnaire (PHQ-9) *(Only complete if you have tinnitus or ringing in the ears.)*

Patient Name: _____ Date: _____

Over the last two weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
For Office Use Only add columns				
TOTAL:				

10. If you check of any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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Generalized Anxiety Disorder Assessment (GAD-7)

(Only complete if you have tinnitus or ringing in the ears.)

Patient Name: _____ Date: _____

Over the last two weeks, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3
For Office Use Only add columns				
TOTAL:				

8. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

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Dizziness Handicap Inventory *(Only complete if you have dizziness.)*

Patient Name: _____ Date: _____

Instructions: The purpose of this scale is to identify difficulties that you may be experiencing because of your dizziness. Please check "Always," "No" or "Sometimes" to each question. Answer each question only as it pertains to your dizziness problem.

	Questions	**Always**	**Sometimes**	**No**
P1	Does looking up increase your problem?			
E2	Because of your problem, do you feel frustrated?			
F3	Because of your problem, do you restrict your travel for business or pleasure?			
P4	Does walking down the aisle of a supermarket increase your problem?			
F5	Because of your problem, do you have difficulty getting into or out of bed?			
F6	Does your problem significantly restrict your participation in social activities, such as going out to dinner, going to movies, dancing or going to parties?			
F7	Because of your problem, do you have difficulty reading?			
F8	Does performing more ambitious activities—like sports, dancing and household chores, such as sweeping or putting dishes away—increase your problem?			
E9	Because of your problem, are you afraid to leave your home without having someone accompany you?			
E10	Because of your problem, have you been embarrassed in front of others?			
P11	Do quick movements of your head increase your problem?			
F12	Because of your problem, do you avoid heights?			
P13	Does turning over in bed increase your problem?			
F14	Because of your problem, is it difficult for you to do strenuous housework or yard work?			
E15	Because of your problem, are you afraid people may think that you are intoxicated?			
F16	Because of your problem, is it difficult for you to go for a walk by yourself?			
P17	Does walking down a sidewalk increase your problem?			
E18	Because of your problem, is it difficult for you to concentrate?			
F19	Because of your problem, is it difficult for you to walk around the house in the dark?			
E20	Because of your problem, do you feel handicapped?			
E21	Because of your problem, are you afraid to stay home alone?			
E22	Has your problem placed stress on your relationship with members of your family or friends?			
E23	Because of your problem, are you depressed?			
F24	Does your problem interfere with your job or household responsibilities?			
P25	Does bending over increase your problem?			

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Medication Documentation

Patient Name: _____ Date: _____

Due to new insurance guidelines for audiologists, it is mandatory that we document current medications prior to billing for your services.

If you have a pre-printed list of your medications, completion of this form is not necessary. Please give that list to the receptionist to copy.

Otherwise, please fill out this form and bring it with you to your appointment.

Below, please list each medication you are currently taking and include the following: prescriptions, over-the-counter, herbals and vitamin/mineral/dietary supplements. Thank you!

Medication Name	Dosage	Frequency	Route: Oral, Shots, Dermal, etc.	Dizziness/ Vertigo (office use only)	Hearing Loss (office use only)	Tinnitus (office use only)

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