Windsor Audiology
Hearing and Tinnitus Clinic

Leann Johnson, Au.D.
Board Certified Doctor of Audiology
Your Hearing Healthcare Journey
Begins Here

MEDICAL/AUDIOLOGIC HISTORY **DATE**_____

Patient Name_____ Patient DOB_____

When/where was your last hearing test? _____

Results of hearing test? _____

History of Hearing Loss? Yes / No Gradual/sudden Date/onset: _____

Ear disease/surgery? □ □ _____

Aural Fullness? □ □ _____

Ear Pain? □ □ _____

Family history of HL? □ □ _____

Head trauma? □ □ _____

Noise exposure? □ □ _____

Dizziness/Vertigo? □ □ _____

Tinnitus/ringing? □ □ _____

How is your general health? _____

History of diabetes? _____

Present medications/ototoxic medications? _____

Recent hospitalizations / surgeries/chemotherapy? _____

Other medical conditions? _____

_____

_____

HEARING AID INFORMATION

Do you wear hearing aids? Yes / No Ear: Right / Left

How long? _____ Are you satisfied with current amplification?_____ If NO please give a brief explanation _____

Do you use assistive listening devices? (i.e. TV listeners, pocket talkers, caption phone, PSAP), If yes what device(s)?

_____

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Hearing Health Questionnaire

Todays Date_____

Patient Name_____ Patient DOB_____

Rate your ability to hear in these different listening situations:

1 = maximum difficulty hearing

2 = a good deal of difficulty hearing

3 = some difficulty hearing

4 = at times you have difficulty hearing

5 = no difficulty hearing at all

Listening Situations	Hearing Quality	Importance to You		
How well do you hear…	(1) Poor - (5) Normal	Not	Somewhat	Very
In Quiet (one on one conversation)	1 2 3 4 5	1	2	3
Television	1 2 3 4 5	1	2	3
During Leisure Activities	1 2 3 4 5	1	2	3
At Restaurants	1 2 3 4 5	1	2	3
At Church	1 2 3 4 5	1	2	3
During Meetings/Groups	1 2 3 4 5	1	2	3
At Your Work Place (if applicable)	1 2 3 4 5	1	2	3
On Your Telephone	1 2 3 4 5	1	2	3
In Your Car	1 2 3 4 5	1	2	3
Male Voices	1 2 3 4 5	1	2	3
Female Voices	1 2 3 4 5	1	2	3
Child's Voices	1 2 3 4 5	1	2	3
Other (please indicate) _____	1 2 3 4 5	1	2	3

Comments _____

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