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: _______________________

	Yes	No	
Ear disease/surgery?	☐	☐	____________________
Aural Fullness?	☐	☐	____________________
Ear Pain?	☐	☐	____________________
Family history of HL?	☐	☐	____________________
Head trauma?	☐	☐	____________________
Noise exposure?	☐	☐	____________________
Dizziness/Vertigo?	☐	☐	____________________
Tinnitus/ringing?	☐	☐	____________________
Do you smoke?	☐	☐	____________________

Do you have an Inflammatory Rheumatic Disorder (ex. Arthritis, Fibromyalgia, Lupus, etc.)? __________________
If yes, what? ____
History of diabetes? ____
Present medications/ototoxic medications? ____
Recent hospitalizations / surgeries/chemotherapy? ____
Do you have an autoimmune disease? ____
Do you have any allergies? ____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING (PLEASE MARK IF YES):

O High blood pressure	O Asthma	O Diabetes
O Heart trouble	O Shortness of breath	O Thyroid problems
O Chest pain	O Bronchitis	O Urinary problems
O Heartburn	O Pneumonia	O Prostate problems
O Stomach/Duodenal ulcer	O Tuberculosis	O Kidney disease
O Intestinal bleeding	O Chronic lung disease	O Blood disorder
O Bowel disorder	O Blood transfusion	O Alcoholism
O Liver problems	O Eye disease	O Epilepsy
O Memory problems	O Drug addiction	O AIDS/HIV
O Anemia	O Stroke	O Hepatitis or Jaundice
O Rheumatic Fever	O Cirrhosis	O Phlebitis or blood clots
O Angina	O Heart Murmur	O Gout
O Depression	O Anxiety	O Glaucoma
O Polio	O Osteoporosis	O COPD
O Syncope (Fainting)	O Substance Abuse	O Arrhythmia(Palpitations)

Continued on back.

• 8201 Spinnaker Bay Drive, Suite E • Windsor • Colorado • P: 970.682.1950 • F: 970.631.8869 •
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List of current medications:

Medication	Dosage	How often?

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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/Worship	1 2 3 4 5	1	2	3
During Meetings/Groups	1 2 3 4 5	1	2	3
At Your Workplace (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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