



## AUDIOLOGY PATIENT QUESTIONNAIRE

PATIENT NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

Please spend a few minutes answering these questions regarding your history and symptoms. Answer them to the best of your ability, but please be assured that how you answer will not affect your evaluation.

Put an 'X' in either the YES box or the NO box, whichever best describes your feelings most accurately.

Do you have any of the following symptoms?

YES NO

Do you have difficulty in hearing?  Both ears  Right ear  Left ear

When did it start? \_\_\_\_\_ Is it getting worse? \_\_\_\_\_

Do you have noise in your ears (tinnitus)?  Both ears  Right ear  Left ear

Describe the noise \_\_\_\_\_

Does the noise change?

If YES, when does it change? \_\_\_\_\_

If YES, how does it change? \_\_\_\_\_

Does anything stop the noise or make it better? \_\_\_\_\_

Do you feel fullness or stuffiness in your ears?  Both ears  Right  Left

Do you have pain in your ears?  Both ears  Right  Left

Do you have discharge from your ears?  Both ears  Right  Left

Have you ever been exposed to loud noise?

If yes, explain \_\_\_\_\_

Do you wear hearing aids?  Both ears  Right  Left

If YES, Do you feel your hearing aids help you hear better?  Yes  No

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**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.**

		Yes 4	Sometimes 2	No 0
E-1	Does a hearing problem cause you to feel embarrassed when you meet new people?.....	_____	_____	_____
E-2	Does a hearing problem cause you to feel frustrated when talking to members of your family? .....	_____	_____	_____
S-3	Do you have difficulty hearing when someone speaks in a whisper?.....	_____	_____	_____
E-4	Do you feel handicapped by a hearing problem?.....	_____	_____	_____
S-5	Does a hearing problem cause you difficulty when visiting friends, relatives, or neighbors?.....	_____	_____	_____
S-6	Does a hearing problem cause you to attend religious services less often than you would like? .....	_____	_____	_____
E-7	Does a hearing problem cause you to have arguments with family members?.....	_____	_____	_____
S-8	Does a hearing problem cause you difficulty when listening to radio or television?.....	_____	_____	_____
E-9	Do you feel that any hearing difficulty limits or hampers your personal or social life? .....	_____	_____	_____
S-10	Does a hearing problem cause you difficulty when in a restaurant with relatives or friends? .....	_____	_____	_____

*Do not write below this line.*

**TOTAL SCORE:** \_\_\_\_\_      **E -TOTAL:** \_\_\_\_\_      **S -TOTAL** \_\_\_\_\_