Pathway Audiology

Patient Name_____

Date of Birth____/____/_____

VA Questionnaire

History:

1. What is your claim for today? (Please Circle) Hearing Loss Tinnitus (Ringing in the Ears) Both

2. Medical History or Diagnoses pertinent to hearing loss or tinnitus: (e.g., ear surgery, Acoustic Neuroma, Cancer, long-term IV antibiotics, head trauma, etc.) _____

3. Military Service History:
   a. Branch of Service (Please Circle): Army Navy Air Force Marine Corps Coast Guard
   b. Dates of Active Service: _____ Dates of Inactive Service: _____
   c. In which did you serve? (Please Circle) Conflict Peacetime
      If Conflict, which Conflict(s)? _____
   d. Please Circle any that you received: Combat Action Badge Combat Infantry Badge Combat Ribbon
   e. Other Military History pertaining to hearing loss or tinnitus: _____
      _____

4. Do you have a family history of hearing loss? ☐ Yes ☐ No
   If yes, who in your family has hearing loss? _____

Noise Exposure:

1. **Military Noise Exposure:** (e.g., explosions, firearms, artillery, aircrafts, heavy equipment, etc.)
   _____
   Did you wear hearing protection during these activities? ☐ Yes ☐ No

2. **Job-Related Noise Exposure:** (e.g., aircrafts, farm equipment, heave equipment, power tools, etc.)
   a. **Pre-Service:** _____
      Did you wear hearing protection during these activities? ☐ Yes ☐ No
   b. **Post-Service:** _____
      Did you wear hearing protection during these activities? ☐ Yes ☐ No

3. **Entertainment/Social Noise Exposure:** (e.g., motorcycles, ATVs, firearms, power tools, music/concerts, etc.)
   a. **Pre-Service:** _____
      Did you wear hearing protection during these activities? ☐ Yes ☐ No
   b. **During Service:** _____
      Did you wear hearing protection during these activities? ☐ Yes ☐ No
   c. **Post-Service:** _____
      Did you wear hearing protection during these activities? ☐ Yes ☐ No

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VA Questionnaire - Continued

Hearing:

1. What year (during the service) did your hearing loss begin? _____

2. What difficulties, if any, do you have with your hearing? (Please Circle)

   Hearing is fine Able to hear but not clearly Trouble in noisy environments Other: _____

3. Does your hearing loss impact ordinary conditions of daily life, including ability to work? ☐ Yes ☐ No
   If yes, describe: _____

4. What daily activities are impacted by your hearing loss? (e.g., conversations with family, phone use, etc.)
   _____

5. What work activities are affected by your hearing loss? (e.g., conversations with clients/coworkers, etc.)
   _____

Tinnitus:

1. Do you have tinnitus (ringing, buzzing, humming, etc. in your ears)? ☐ Yes ☐ No
   If yes, when did it start? _____

2. Which ear is your tinnitus in? (Please Circle) Right Ear Left Ear Both

3. What best describes your **current** tinnitus? (Please Circle All That Apply)

   Comes and Goes Constant High Pitched Low Pitched Other (describe): _____

4. What were the circumstances when your tinnitus started? _____

5. How frequently does your tinnitus occur? (Please Circle) Daily Weekly Monthly Yearly

6. Since starting, your tinnitus has (Please Circle): Remained the Same Gotten Worse Improved

7. Does your tinnitus impact ordinary conditions of daily life, including ability to work? ☐ Yes ☐ No
   If yes, describe: _____

8. What daily life activities are impacted by tinnitus? (e.g., sleep, focus, conversations with family, etc.)
   _____

9. What work activities are affected by tinnitus? (e.g., focus on tasks, conversations with clients/coworkers, etc.)
   _____