Tinnitus & Hyperacusis Questionnaire

Please answer the following questions and return to our office. If you need more space for an answer, write it on a separate sheet of paper and indicate the question and page number.

Date: ________________________________

Name: ____

Address: ____

____

Phone: _____________________________ Cell: _____________________________

E-mail: __________________________________ Fax: ________________________

Date of Birth: ________________________ SSN: ____________________________

Occupation: ____

Insurance Company: ____________________ Insurance ID#:___________________

Referred by or physician you would like copy of records sent to (complete address and zip):

Name:

____

Address:

____

____

Medical History

Current medical/health problems: ____

____

Major surgery(ies) in the past: ____

____

List all current medications and doses (please print)

Name of drug (e.g. Aspirin)	Dosage (e.g.. 325 mg per day)	How long (e.g. last 2 years)

Indicate medication allergies: None _____ List: ______________________________________

List health problems that run in your family: ____

____

Tobacco use: No ____ Yes ____ How much: ____________________________

Alcohol use: No ____ Yes _____How much: ____________________________

Street drug use: No ____ Yes _____ How much: ____________________________

Review of Symptoms

Do you have problems with any of the following? Please circle no or yes. If 'yes', please write explanation to the right.

Breathing/Respiratory System	NO	YES	
Heart/Blood pressure	NO	YES	
Digestive system	NO	YES	
Urinary tract/kidney	NO	YES	
Reproductive system	NO	YES	
Bone & joint	NO	YES	
Diabetes or thyroid	NO	YES	
Skin problem	NO	YES	
Neurologic impairment/headaches	NO	YES	
Infections	NO	YES	
General (weight loss, fever)	NO	YES	
Anxiety or psychological	NO	YES	
Changes in appetite (no appetite/ravenously eating)	NO	YES	
Sleep disorder (e.g. sleep apnea)	NO	YES	
No energy/often fatigued	NO	YES	
Restless and irritable	NO	YES	
Feeling worthless, hopeless	NO	YES	
Difficulty thinking, concentrating	NO	YES	
Thoughts of death	NO	YES	
Attempts at suicide	NO	YES	
Pessimistic about life goals	NO	YES	
Chronic aches and pains	NO	YES	

Otologic history

Do you have hearing loss? No ____Yes ____ Left ____ Right ____ How Severe?_____________
Cause of hearing loss: ____ Unknown _______
Duration of hearing loss: ____
Is your hearing changing: No _____Yes _____Progressive _____Fluctuating _____Stable_____
Have you ever used hearing aids? No _____ Yes _____ How Long? ______________________

Do you have dizziness? No _____ Yes ______
Is this dizziness a feeling of being light headed OR is the room/world spinning around?
____
Is your dizziness: Constant _______ Episodic _________ How Frequent? ________________
Is our tinnitus related to dizziness in any way? No _________ Yes __________
How? ____

Do you have a history of any of the following? Please circle no or yes. If 'yes' please write explanation to the right.

Ear infections	NO/YES	
Noise exposure	NO/YES	
Family history of hearing loss	NO/YES	
Family history of tinnitus	NO/YES	
Family history of sound intolerance	NO/YES	
Head trauma	NO/YES	
Explosive injuries to the ear	NO/YES	
Intravenous antibiotics	NO/YES	

Tinnitus questions

When did you first become aware of having tinnitus? __________________________________
In which ear is your tinnitus? (Please circle): Right Left Both Not in ears – in head
If tinnitus is in both ears, is one side louder than the other? No ________ Yes _______
What does it sound like? (Please circle): Ringing Hissing Humming Crickets Seashell
Other (please describe): ____
Is the volume of the tinnitus stable, or does it change? __________________________________
Is it synchronized with your heartbeat? No ________ Yes _________
Does anything make your tinnitus change? No __________ Yes _________
(If 'yes', please explain): ____
Is the tinnitus made worse by exposure to a sound? No _______ Yes _______
(if 'yes', how long does it stay worse after sound exposure): ______________________________
List all methods, procedures, medications, or devices you have tried for your tinnitus and the treatment outcome: ____
____

Have you seen other ear specialists about your tinnitus? No _____ Yes _____ How Many? ____
What were you told?: ____

What tests were done by these specialists?

Audiogram	NO	YES	Date/Outcome?
ABR	NO	YES	Date/Outcome?
CT Scan	NO	YES	Date/Outcome?
MRI Scan	NO	YES	Date/Outcome?
ENG	NO	YES	Date/Outcome?
Other (specify)	NO	YES	Date/Outcome?

Do you have decreased tolerance to everyday sound? No _______ Yes _______
When did it start? ____
List uncomfortable sounds: ____
Do you were ear protection (plugs or muffs)? No _______ Yes ________
If yes, estimate the percentage of time you wear them: ________________________________
Do you wear ear protection in quiet situations? No ________ Yes ________

List all methods, procedures, medications, or devices you have tried for your sound tolerance problems and the treatment outcome: ____
____

Have you seen other ear specialists about your sound tolerance problems? No ____ Yes _____
How many? _______________ What were you told? _________________________________
____

Are there activities that you are prevented from doing, or are affected by the tinnitus, sound tolerance problem or hearing loss?
Please check yes/no/not sure in all three categories:

ACTIVITY	**TINNITUS**				**SOUND TOLERANCE**				**HEARING LOSS**		
	Yes	No	Not sure		Yes	No	Not sure		Yes	No	Not sure
Concentration											
Falling asleep											
Staying asleep											
Restaurants											
Social events											
Church											
Sport events											
Activities in quiet											
Concerts											
other											

Have you ever worked anywhere that exposed you to continuously loud noise, such as a factory, jackhammer use, or airport? No ______ Yes _______
If 'yes', describe noise and duration of exposure: ______________________________________
____

Estimate the percentage of time over <u>a period of a month</u> that you are in:

(1.) A **quie**t environment (i.e.: like a quiet home, where you could speak with a soft voice and still be understood**).** **Quiet _ _________%**
(2.) A **moderate** environment (i.e.: like an office, restaurant, out in public, where you will have to speak with a normal voice). **Moderate __________%**
(3.) A **loud** environment (i.e. loud work place, concert, a loud radio or tv, where you would find it necessary to increase your voice to be understood**).** **Loud __________%**

Estimate the percentage of time over the past month that you were aware of the tinnitus:___%
What percentage of that time did the tinnitus annoy you? _________%

Do you feel depressed: No ______ Yes _______ If 'yes', explain why: ___________________
____

Did you have any depression or anxiety before the onset of tinnitus or sound tolerance problems? No ____ Yes ____ If 'yes', what typically set off this depression? ______________
____

Do you have legal action pending in relation to your tinnitus/sound tolerance problems/hearing loss/or are you planning legal action? No ______ Yes _____ If 'yes', please explain: _______
____

On a scale of 0 to 10 (0 = none; 10 = as bad as you can imagine), please indicate (circle the number value) the influence tinnitus, sound tolerance problems, and/or hearing loss have on your life:

Tinnitus	0	1	2	3	4	5	6	7	8	9	10
Sound Tolerance Problems	0	1	2	3	4	5	6	7	8	9	10
Hearing Loss	0	1	2	3	4	5	6	7	8	9	10

What is the greatest concern for you? Tinnitus / Sound Tolerance / Hearing Loss
(please circle one)

Please add any other information relevant to your problem(s):

____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____