TINNITUS & HYPERACUSIS QUESTIONNAIRE

(Please Print)

Name: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____ Home Phone: _____

_____ Work Phone: _____

Gender: _____ Cell Phone: _____

Occupation: _____ Email: _____

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

Name: _____ Address: _____

_____

PAST MEDICAL HISTORY

Please list all your current medications and dosage information below. This should include prescription, non-prescription, and herbal remedies you take. Attach additional sheets as necessary.

	Name of Medication *Example: Aspirin*	Dose *Example: 325 mg / 1 per day*	How Long *Example: last 2 years*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Current medical/health problems: _____

_____

Major surgery in past: _____

_____

Please indicate medication allergies: ☐ None List: _____

_____

Please list health problems that run in your family: _____

_____

Tinnitus & Hearing Center of Arizona

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REVIEW OF SYMPTOMS

Do you have problems with any of the following? If yes, please explain:

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, Headache:	☐ No	☐ Yes	_____
Infections:	☐ No	☐ Yes	_____
General (Weight Loss/Fever):	☐ No	☐ Yes	_____
Anxiety or Psychological:	☐ No	☐ Yes	_____
Change in Appetite:	☐ No	☐ Yes	_____
Sleep Disorder:	☐ No	☐ Yes	_____
No Energy, Often Fatigued:	☐ No	☐ Yes	_____
Restless and Irritable:	☐ No	☐ Yes	_____
Feeling of Worthlessness, Hopeless:	☐ No	☐ Yes	_____
Difficulty Thinking, Concentrating:	☐ No	☐ Yes	_____
Thought of Death:	☐ No	☐ Yes	_____
Attempts of Suicide:	☐ No	☐ Yes	_____
Pessimistic About Life Goals:	☐ No	☐ Yes	_____
Chronic Aches and Pains:	☐ No	☐ Yes	_____

OTOLOGIC HISTORY

Do you have a hearing loss? ☐ No ☐ Yes ☐ Left ☐ Right ☐ Both How Severe? _____

Cause of hearing loss: _____

Duration of hearing loss: _____

Is your hearing changing? ☐ No ☐ Yes ☐ Progressive ☐ Fluctuating ☐ Stable

Have you ever used hearing aids? ☐ Left ☐ Right ☐ Both ☐ None

Do you have dizziness? ☐ No ☐ Yes

Is your dizziness: ☐ Constant ☐ Episodic How Frequent? _____

Is your tinnitus related to your dizziness in any way? ☐ No ☐ Yes How? _____

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Do you have a history of?

ear infections:	☐ No ☐ Yes	noise exposure:	☐ No ☐ Yes
familial hearing loss:	☐ No ☐ Yes	familial tinnitus:	☐ No ☐ Yes
familial decreased sound tolerance:	☐ No ☐ Yes	head trauma:	☐ No ☐ Yes
explosive injury to the ears:	☐ No ☐ Yes	intravenous antibiotics use:	☐ No ☐ Yes
loop diuretics use:	☐ No ☐ Yes	chemotherapy:	☐ No ☐ Yes

NOISE HISTORY

Exposure to gunfire or explosion: ☐ No ☐ Yes Details: _____

Attended loud events e.g. concerts/clubs: ☐ No ☐ Yes Details: _____

Had any noisy jobs: ☐ No ☐ Yes Details: _____

Had any noisy hobbies or home activities: ☐ No ☐ Yes Details: _____

Had any head injuries or concussion: ☐ No ☐ Yes Details: _____

Had any surgery involving ears/head/brain: ☐ No ☐ Yes Details: _____

MEDICATIONS

☐ No ☐ Yes Details: _____

Have you ever taken any of the following medications? Quinine, Quindidine, Chloroquine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin, Tobramycin, Erythromycin, Cisplatin, Buserelin, Vinblastine, Vincristine, Gentamicin, Amikacin, Ethacrynic Acid, Furosemide

CHEMICALS

☐ No ☐ Yes Details: _____

Have you ever used solvents, thinners, or alcohol based cleaners such as the following? Toluene, Styrene, Xylene Dinitrobenzene, Carbon Disulfide, Trichloroethylene, Heptane, Hexane, Butyl Nitrite, Butyl Alcohol, Trimethyltin

DENTAL

☐ No ☐ Yes Details: _____

Loose dentures, jaw pain, grinding or clicking sensations in the jaw:

Have any feelings of ear pressure or blockage: ☐ No ☐ Yes Details: _____

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TINNITUS/HYPERACUSIS QUESTIONS

Initial onset: When did you first become aware of having tinnitus? _____

Was the onset gradual or sudden? _____

What do you consider to have started the tinnitus? i.e. loud blast of sound, whiplash, change in hearing, stress, head trauma, otitis media, dental treatment, etc. _____

_____

Family history of tinnitus complaints? ☐ No ☐ Yes If yes: ☐ Parents ☐ Siblings ☐ Children

Where is the location of your **most bothersome** tinnitus? (right ear, left ear, both ears equally, both ears-worse in left ear, both ears-worse in right ear, outside the head, inside the head) _____

_____

Please describe in your own words what your tinnitus usually sounds like. The following list gives examples of some possible sensations; feel free to use other terms as well: ringing, hissing, tonal, high tension wire, buzzing, more than 1 tone, pulsating, roaring, rushing, whistling, whooshing, pounding, music, transformer noise, clicking, cracking, sizzling, humming, popping, crickets, seashell. _____

Does your tinnitus sound more like a tone or more like noise? _____

Please describe the PITCH of your tinnitus: very high frequency, high frequency, medium frequency, low frequency?

_____

Does the volume of your tinnitus vary from day to day? ☐ No ☐ Yes

If yes, how often does it change? _____

❍ Several times per month ☐ Several times per week ☐ Several times per day ☐ Several times per hour

Describe the volume of your tinnitus using a scale from 1-100 (1=very faint; 100=very loud):

Is your tinnitus a constant or intermittent sound? _____

Is your tinnitus pulsing or rhythmic? _____

Is it synchronized with your heartbeat? Different from heartbeat? _____

Is your tinnitus reduced by music or by certain types of environmental sounds such as the noise of a waterfall or the noise of running water when you are standing in the shower? _____

Does the presence of loud noise make your tinnitus worse? _____

Is there anything specific that you are aware of that makes your tinnitus louder or softer? _____

_____

Does any head and neck movement (e.g. moving your jaw forward or clenching your teeth), or having your arms/hands or head touched, affect your tinnitus? _____

Does taking a nap during the day affect your tinnitus? ☐ Worsens ☐ Reduces ☐ No Effect

Is there any relationship between sleep at night and your tinnitus during the day? _____

Does stress influence your tinnitus? ☐ Worsens ☐ Reduces ☐ No Effect

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Does medication have an effect on your tinnitus? Please provide details. _____

_____

When you hear a sound that causes your tinnitus to change, does the effect last until the next morning after you've slept? What kinds of sounds cause this to happen? _____

_____

List all methods, procedures, medications, or devices you have tried for your tinnitus and the treatment outcome. _____

_____

_____

Have you seen other specialists/ear specialists about your tinnitus? ☐ No ☐ Yes

How many and who? _____

What were you told? _____

What tests were done?

Audiogram:	☐ No ☐ Yes	Dates(s):	_____
ABR:	☐ No ☐ Yes	Dates(s):	_____
CT Scan:	☐ No ☐ Yes	Dates(s):	_____
MRI:	☐ No ☐ Yes	Dates(s):	_____
ENG/VNG:	☐ No ☐ Yes	Dates(s):	_____
Other:	☐ No ☐ Yes	Dates(s):	_____

What is the **biggest reason** your tinnitus is a problem? _____

_____

Do you have a problem tolerating sounds because they often seem much too loud? That is, do you often find that sounds are too loud or hurtful which other people around you find quite comfortable?

☐ Never ☐ Rarely ☐ Sometimes ☐ Usually ☐ Always

Do sounds cause you pain or physical discomfort? _____

What kinds of sounds are bothersome or unpleasant? _____

Do you suffer from headaches? _____

Do you suffer from vertigo or dizziness? _____

Do you suffer from temporomandibular joint (TMJ) disorder? _____

Do you suffer from neck pain? _____

Do you suffer from other pain syndromes? _____

Are you currently under treatment for psychological/psychiatric care? _____

Do you wear ear protection (plugs or muffs)? ☐ No ☐ Yes

If yes, estimate the percentage of time you wear them: _____%

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Why do you use ear protection?

☐ To keep tinnitus from getting louder.

☐ Trouble tolerating everyday sounds that seem normal to others

☐ Other: _____

Do you wear ear protection in quiet situations? ☐ No ☐ Yes

List all methods, procedures, medications, or devices you have tried for decreased sound tolerance and the treatment outcome. _____

_____

Have you seen other specialists/ear specialists about sound tolerance? _____

How many and who? _____

What were you told? _____

Are there activities that you are prevented from doing, or are they affected by your tinnitus/sound tolerance? Please mark yes/no/not sure below:

	TINNITUS			SOUND TOLERANCE			HEARING LOSS		
Activity	Yes	No	Not Sure	Yes	No	Not Sure	Yes	No	Not Sure
Concentration	☐	☐	☐	☐	☐	☐	☐	☐	☐
Falling Asleep	☐	☐	☐	☐	☐	☐	☐	☐	☐
Staying Asleep	☐	☐	☐	☐	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐	☐	☐	☐	☐
Social Events	☐	☐	☐	☐	☐	☐	☐	☐	☐
Church	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sports Events	☐	☐	☐	☐	☐	☐	☐	☐	☐
Activities in the Quiet	☐	☐	☐	☐	☐	☐	☐	☐	☐
Concerts	☐	☐	☐	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐	☐	☐	☐

How has tinnitus/hyperacusis affected your work life? _____

How has tinnitus/hyperacusis affected your home life? _____

How has tinnitus/hyperacusis affected your social activities? _____

Estimate the percentage (1-100) of time over a period of one month when you are in:

i) a quiet environment (i.e. quiet home - you could speak with a soft voice and still be understood) Quiet _____%

ii) a moderate environment (average street noise, office, restaurant - you typically speak in a normal voice and can be understood) Moderate_____%

iii) a loud environment (loud workplace, very loud TV or radio - it would be necessary to raise your voice to be understood). Loud _____%

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What percent of your **total awake time**, over the last month, were you were **noticing, or thinking about** your tinnitus? Please circle the average percentage over the last month.
5, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, or 100%.

What percent of your total awake time, over the last month, were you **annoyed**, **distressed**, or **irritated** by your tinnitus? Please circle the average percentage over the last month.

5, 10, 15, 20, 25, 30, 35, 40, 45, 50, 55, 60, 65, 70, 75, 80, 85, 90, 95, or 100%.

Do you feel depressed? ❍ No ❍ Yes If yes, please explain why: _____

_____

Did you have any depression or anxiety before the onset of tinnitus or decreased sound tolerance?
❍ No ❍ Yes If yes, when? _____

Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claim, or any other legal action now or in the future? ☐ No ☐ Yes

On a scale from 0 to 10 (**0=none; 10=as bad as you can imagine**), please indicate the influence your tinnitus, sound tolerance, and hearing loss has on your life.

Tinnitus:	0	1	2	3	4	5	6	7	8	9	10
Sound Tolerance:	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 most troublesome for you? ☐ Tinnitus ☐ Sound tolerance ☐ Hearing loss

What is the least troublesome for you? ☐ Tinnitus ☐ Sound tolerance ☐ Hearing loss

Please provide any additional information we should be aware of relevant to your problem(s).

_____

_____

MEDICAL CONTACT DETAILS

Primary Care Physician: _____

Ear, Nose, and Throat Specialist: _____

Dentist/TMJ Specialist: _____

Neurologist: _____

Psychologist: _____

Psychiatrist: _____

Other: _____

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