

Tinnitus/Hyperacusis History Form

Name

Date of Birth

Age

Today's Date

Referred by

Doctors Fax #

Your Phone number

When did you first experience tinnitus/hyperacusis?

Briefly describe what you were doing when you first became aware of tinnitus/hyperacusis.

How long have you had tinnitus/hyperacusis in its present form?

What do you think is the cause of the tinnitus/hyperacusis?

Was the onset gradual or sudden?

Please check all items that are applicable to you:

- History of poor health for much of life
- History of ear infections
- History of ear surgery
- History of other ear disease
- History of ear pain
- History of sinusitis or Eustachian tube dysfunction (plugged up feeling)
- History of hearing loss
- Sudden change in hearing or balance with onset of tinnitus
- History of migraines
- History of headaches or tension in neck
- History of hypertension (high blood pressure)
- History of vertigo or dizziness
- History of facial pain, numbness, or tingling
- History of cancer or tumor
- History of diabetes
- History of heart disease or other cardiovascular problem
- History of kidney disease
- Fair to poor dietary habits
- Moderate to excessive intake of caffeine
- History of chronic fatigue
- History of chronic pain
- History of depression
- History of anxiety
- History of obsessive compulsive behavior
- History of significant stress
- History of psychological or psychiatric care
- History of drug or alcohol problem
- History of teeth grinding or pain in jaw
- History of neck injury (whiplash)
- History of head injury
- History of thyroid dysfunction (hypo or hyper)
- History of food allergies
- History of Lyme disease
- History of Epstein-Barr virus, cytomegalovirus, or hepatitis (**circle**)
- High intake of aspirin containing drugs
- New medication or stopped medication around onset of tinnitus
- History of high noise exposure activities
- Family history of tinnitus
- History of chronic aspirin or other NSAID use

Where is your tinnitus primarily localized, where do you perceive its origin?

The head Right ear Left ear Both ears equally

Other (please explain) _____

Check all items below that describe the sound of your tinnitus:

- Hissing
- Ringing
- Buzzing
- Sizzling
- Crickets
- Whistle
- Tea kettle
- High tension wire
- Breaking glass
- Ocean roar
- Clicking
- Typewriter
- Fluttering
- Pulsing
- Heartbeat
- Other (please describe) _____

Using the scale below, indicate the loudness of your tinnitus (write number in blank):

- Now
 - Average
 - At its worst
 - At its least
- 0 1 2 3 4 5 6 7 8 9 10
None Mild Moderate Severe Excruciating

Using the scale below, indicate the pitch of your tinnitus, pitch meaning like on a piano scale from lower bass like sounds to higher pitch treble sounds (circle on scale).

- 0 1 2 3 4 5 6 7 8 9 10
Low pitch Mid Pitch High pitch

Does your tinnitus fluctuate? (check one)

- Fairly constant day to day
- Fluctuates widely, very loud some days and very mild other
- Usually constant, but occasionally decreases
- Usually constant, but occasionally increases
- Can modulate with head position or movement

Most persons with tinnitus can listen and hear their tinnitus at any time during the day, but often they can go some period of time not actively paying attention to the tinnitus, how much of the day are you actively engaged to perceiving your tinnitus (check one)?

- 24 hours 7 days a week, can't ignore, always perceive, even in noise and when distracted
- about 75% of the day
- about 50% of the day
- about 25% of the day
- Only perceive in very quiet
- Only perceive when going to bed or awaking from sleep

Does your tinnitus appear worse or more bothersome (check all that apply):

- When tired
- When stressed
- When have a head cold
- At bedtime
- When performing a quiet activity (e.g. reading)
- After use of alcohol
- After specific food or medication
- Upon awakening
- When relaxed
- After exercise
- After noise exposure
- When at work
- After work
- When discussing tinnitus
- When researching tinnitus on internet
- Other (describe) _____

Does your tinnitus appear better or less bothersome (check all that apply):

- With other sound around (tv, traffic, music, etc.)
- When at work
- After work
- When doing something you enjoy
- When distracted
- When you are having fun
- When wearing a hearing aid
- Other (describe) _____

Because of your tinnitus (check all that apply):

- You can't sleep
- You are stressed
- You can't hear as well
- You are depressed
- You have stopped going out or socializing
- You have stopped a hobby or something you enjoy (describe) _____
- You feel you can't escape the tinnitus
- You feel you can't enjoy life
- You feel that if not for the tinnitus you would be happy

To what extent are you bothered or annoyed by your tinnitus? (circle)

0 1 2 3 4 5 6 7 8 9 10
Not Bothered Mild Moderate Severe Extreme

Have you discussed your tinnitus with your family or friends?

Yes No

What was their reaction?

Do you feel like you have hearing loss?

Yes No

Which ear?

Right ear Left ear Both ears equally One side worse

Other (please explain) _____

Was the hearing loss sudden or gradual? (circle sudden or gradual)

Have you had a hearing test in the past year?

Yes No

Have you ever worn hearing aids?

Yes No

Do you feel like you are more sensitive to sounds (if yes check all that apply)?

Yes No

All loud sounds

Only high pitch loud sounds

Moderate level sounds

Soft sounds (e.g. chewing, slurping, etc.)

All sounds

Specific sounds _____

Please list all evaluations and treatments you have had for your tinnitus/hyperacusis, including imaging, surgery, counseling, ENT, and etc.

	Provider	What was done?	Date	Result
1.				
2.				
3.				
4.				
5.				

Please list all current and past medications you have used to help with your tinnitus/hyperacusis, including over the counter products and herbal remedies

Medication	Dose	How often?	Does it help?	Doctor

Please indicate any treatments you have tried for your tinnitus/hyperacusis and use the number code to indicate the results (1=major relief, 2=some relief, 3=no relief, 4=some relief with bad side effects, 5=tinnitus worse, leave blank if have not tried)

- | | |
|--|---|
| <input type="checkbox"/> Surgery | <input type="checkbox"/> Acupuncture |
| <input type="checkbox"/> Drug therapy | <input type="checkbox"/> Massage |
| <input type="checkbox"/> Hearing aids | <input type="checkbox"/> Chiropractic |
| <input type="checkbox"/> Masking (noise) | <input type="checkbox"/> Relaxation exercises |
| <input type="checkbox"/> Exercise | <input type="checkbox"/> Therapy or counseling |
| <input type="checkbox"/> Dental | <input type="checkbox"/> Diet management or vitamins |
| <input type="checkbox"/> Stopping medication | <input type="checkbox"/> Ear plugs |
| <input type="checkbox"/> Tinnitus retraining therapy | <input type="checkbox"/> Other sound therapy (neuromonics, soundcure, etc.) |
| <input type="checkbox"/> Supplement (over the counter or herbal) | |
| <input type="checkbox"/> Other: _____ | |

Is there anything else about your tinnitus/hyperacusis you would like to comment about?

Do you have legal action pending in relation to tinnitus?

Yes No

If not, are you planning or considering legal action?

Yes No