TINNITUS AND HYPERACUSIS PATIENT QUESTIONNAIRE

Name: Date:

Date of Birth: Age: Gender:

Referred by:

1. When did you first become aware of having tinnitus?

2. If you have hyperacusis (hypersensitivity to loud sounds), when were you first aware of this problem?

3. In which ear is your tinnitus (right, left, both, not in the ears, in the head)?

4. If your tinnitus is in both ears, is one side louder than the other?

5. What does your tinnitus sound like (for example, ringing, crickets, humming, etc)?

6. Is the volume of tinnitus stable, or does it change?

   Is it a pulsing sound that changes in time with your heartbeat?

7. What seems to make the tinnitus or hyperacusis change?

8. Is it made worse by exposure to a sound?

   If so, how long does it stay bad after sound exposure?

9. List all methods, procedures, medications, or devices you have tried for your tinnitus, and the treatment outcomes (include an additional sheet if you want).

10. Have you seen ear specialists about your tinnitus?

    How many?

    What were you told?

11. Do you have a hearing loss?

    If so, please describe.

12. Do you wear a hearing aid (s)?

13. Are you uncomfortable around certain sounds?

14. Do you wear ear protection (plugs or muffs)?

    If so, about what percentage of time do you wear them?

15. Do you wear ear protection in quiet situations?

16. Do you experience pain in the ears from loud sounds?

17. Have you ever worked anywhere that exposed you to continuous loud noise?

18. Estimate the percentage of time over the past month that you have been aware of the tinnitus?

19. Estimate the percentage of time over a month period (not counting sleeping) when you are:

    a) In a quiet environment (e.g., quiet home; you can be understood even when speaking softly) _____ %

    b) Moderate environment (e.g., average street, office, restaurant) _____ %

    c) Loud environment (noisy work place, very loud radio or TV) _____ %

20. Are there activities that you are prevented from doing, or that are affected by the tinnitus/hyperacusis? Indicate with an "X" your answers in the areas below.

Activity	Tinnitus			Hyperacusis		
	Yes	No	Not sure	Yes	No	Not sure
Concentration	___	___	___	___	___	___

Falling asleep	___	___	___	___	___	___
Staying asleep	___	___	___	___	___	___
Restaurants	___	___	___	___	___	___
Social events	___	___	___	___	___	___
Church	___	___	___	___	___	___
Sports events	___	___	___	___	___	___
Quiet activities (e.g., reading)	___	___	___	___	___	___
Concerts	___	___	___	___	___	___
Other	___	___	___	___	___	___

21. Do you feel depressed?

    If so, please explain why?

22. Did you have any depression or anxiety before the onset of tinnitus or hyperacusis?

    If so, when?

23. What medications are you currently taking, and what is each for (use an additional sheet if necessary)?

24. Do you have any legal action pending in relation to your tinnitus or hyperacusis, or are you planning legal action?

25. On the scale of 0 to 10 (0 = none; 10 = totally ruined), indicate the influence tinnitus and hyperacusis have on your life.

26. Rank (indicate by a number) how much these concern you (1 = most and 3 = least):

    _____ Tinnitus _____ Hyperacusis _____ Hearing loss

27. Please write below any other information related to your tinnitus or hyperacusis: