PIONEER HEARING & TINNITUS

YOUR JOURNEY, OUR EXPERTISE

# Tinnitus Hyperacusis

Patient Name: _____ Date: _____

(Last) (First)

Date of Birth: ___ / ___ / ___ Age: ___ Female: ☐ Male: ☐

Referred by: _____

**Please fill out the below questions:**

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 make 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 additional sheet if you want)

10. Have you seen ear specialists about your tinnitus? How many?

    What were you told?

*Tinnitus Hyperacusis Continued*

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)?

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 quite 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?

| **ACTIVITY** | **TINNITUS** (Circle one) | **HYPERACUSIS** (Circle one) |
|---|---|---|
| CONCENTRATION | **Yes / No / Not sure** | **Yes / No / Not sure** |
| FALLING ASLEEP | **Yes / No / Not sure** | **Yes / No / Not sure** |
| STAYING ASLEEP | **Yes / No / Not sure** | **Yes / No / Not sure** |
| RESTAURANTS | **Yes / No / Not sure** | **Yes / No / Not sure** |
| SOCIAL EVENTS | **Yes / No / Not sure** | **Yes / No / Not sure** |
| CHURCH | **Yes / No / Not sure** | **Yes / No / Not sure** |
| SPORTS EVENTS | **Yes / No / Not sure** | **Yes / No / Not sure** |
| QUIET ACTIVITIES (e.g., reading) | **Yes / No / Not sure** | **Yes / No / Not sure** |
| CONCERTS | **Yes / No / Not sure** | **Yes / No / Not sure** |
| OTHER | **Yes / No / Not sure** | **Yes / No / Not sure** |

*Tinnitus Hyperacusis Continued*

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: