

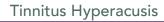


Patient Name:	Date:				
(Last) (First) Date of Birth: / Age:	Female: Male:				
Referred by:					
Please fill out the below questions:					
I. When did you first become aware of having tinnitus?					
2. If you have hyperacusis (hypersensitivity to loud sounds), when were you first aware of this problem?					
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?					
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5. What does your tinnitus sound like (for example, ringing, crickets, humming, e	040)2				
5. What does your tilllitus sound like (for example, ringing, crickets, numining, e	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	r sound exposure?				
List all methods, procedures, medications or devices you have tried for your t	tinnitus, and the treatment outcomes?				
(Include additional sheet if you want)					
10. Have you seen ear specialists about your tinnitus? How many?					
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What were you told?					
Titlat were you told.					





11.	Do you have a hearing loss? If so, please describe:			
12	Do you wear a hearing aid(s)?			
12.	Do you wear a nearing aid(s):			
13.	Are you uncomfortable around certain	sounds?		
14	Do you wear ear protection (plugs or	muffs\?		
11.	Do you wear ear protection (plugs or	munis).		
15.	15. Do you wear ear protection in quiet situations?			
16.	Do you experience pain in the ears fro	m loud sounds?		
	, , , ,			
17.	Have you ever worked anywhere that	exposed you to continuous loud noise?		
18.	Estimate the percentage of time over t	the past month that you have been aware of	the tinnitus?	
19.	Estimate the percentage of time over a	a month period (not counting sleeping) when	n 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		%	
20				
20.	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 RESTAURANTS	Yes / No / Not sure Yes / No / Not sure	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	





21. Do you feel depressed? If so, p	ease explain why?			
22. Did you have any depression of	ression 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 (I = most and 3 = least):				
TINNITUS	HYPERACUSIS	HEARING LOSS		
27. Please write below any other information related to your tinnitus or hyperacusis:				