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TINNITUS CASE HISTORY

Name _____ Date _____
Address _____
_____
Telephone Number _____
Date Of Birth _____

GENERAL INFORMATION

Primary Care Physician _____
Referring Physician _____
Have you been to this office before?
NO YES How long ago? _____
Who referred you for this evaluation?
___ Self
___ Spouse / Family member
___ Friend
___ Doctor Doctor Name _____
___ Nurse/LPN Name _____
___ Other _____
For what reason was this appointment scheduled?
___ To evaluate hearing
___ Ringing in the ear(s)
___ Sound Senility
___ Dizziness/Loss of balance
___ Ear Infection(s)
___ Other_____

HISTORY

Check the following that may apply:
___ History of ear "problems"
___ History of ear surgery
___ History of dizziness or loss of balance
___ History of occupational or recreational noise exposure (military, hunting, construction, factory etc.)
___ History of allergy or sinus problems

___ Family history of hearing loss
___ Family history of dizziness or loss of balance
___ Family history of illness
___ Other medical conditions _____

MEDICATIONS

Please list all medications you are currently taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

HEARING LOSS - 0 1 2 3 4 5 6 7 8 9 10

Do you have a known hearing loss?

NO YES

Is one ear better than the other?

RIGHT LEFT BOTH EARS ARE THE SAME

How long have you noticed the hearing loss

_____DAYS _____WEEKS _____MONTHS _____YEARS

Has the hearing loss occurred gradually over time or suddenly?

GRADUALLY SUDDENLY

Do you know the cause of your hearing loss?

NO YES *Please list:*_____

Do you have any history of noise exposure such as military service, construction, machinery, dentistry, police, fireman, hunting, musician, etc?

NO YES *Please list*:_____

COMMUNICATION

Do you have problems hearing in the following situations?

___ Normal conversations
___ Group situations
___ Background noise
___ At work
___ Television
___ Telephone
___ Other _____

Do you feel you have difficulty hearing, understanding or both? Please circle:

HEARING UNDERSTANDING BOTH

Is there anything you do not do because of hearing difficulties? _____

_____

_____

HEARING AID(S)

I am currently using a hearing aid(s)

NO YES

Hearing Aid information

Date of Purchase _____

Fitting Facility _____

Right ear NONE IN THE EAR BEHIND THE EAR

Left ear NONE IN THE EAR BEHIND THE EAR

I feel my hearing aid(s) help me hear better

NO YES

If no please explain _____

I feel my hearing aid(s) help me understand better

NO YES

If no please explain _____

SOUND SENSITIVITY - 0 1 2 3 4 5 6 7 8 9 10

Do you feel that you have sound sensitivity?

NO YES

If yes how long has it been present?

_____DAYS _____WEEKS _____MONTHS _____YEARS

Do you remember when the sound sensitivity began? Please explain _____

_____

What do you believe started your sound sensitivity? _____

_____

Do you feel that your sound sensitivity has increased in severity over time? _____

When is your worst time of day? _____

Is there anything that makes your sound sensitivity better? _____

_____

Is there anything that makes your sound sensitivity worse? _____

_____

What percentage of time are you aware of your sound sensitivity? _____

What percentage of time are you disturbed by your sound sensitivity? _____

Do you currently use hearing protection? If so when? _____

_____

Do you feel that your sound sensitivity has made you alter your daily life? _____

_____

Is there anything that you do not do because of your sound sensitivity? _____

_____

_____

Have you seen anyone previously regarding your sound sensitivity? If so what did they say? _____
_____

What have you done to try to manage this in the past? _____
_____
_____

Did you feel that your previous attempt was successful? _____
Is there anything you do not do because of your sound sensitivity? _____
_____
_____

Sound Sensitivity Hyperacusis Misophonia Phonophobia

TINNITUS - RINGING / SOUND IN THE EAR(S) 0 1 2 3 4 5 6 7 8 9 10

Do you feel you have tinnitus?
NO YES
Do you hear your tinnitus in your ear(s) or head?
EAR(S) HEAD BOTH

If yes how long has the tinnitus been present?
_____DAYS _____WEEKS _____MONTHS _____YEARS
Do you remember when the tinnitus began? Please explain _____
_____
Do you feel that your tinnitus has increased in severity over time? _____
Where is the tinnitus present?
RIGHT SIDE LEFT SIDE CENTER
Is there a primary tinnitus ear?
RIGHT LEFT
Is the tinnitus constant or does it occur in episodes?
CONSTANT EPISODIC
Is the tinnitus a high pitch (bird chirp) or a low pitch (deep like a fog horn)
HIGH PITCH LOW PITCH
Is the tinnitus pulsing or steady?
PULSING STEADY RHYTHMIC
Does the tinnitus fluctuate in volume?
YES NO
Please describe what your tinnitus sounds like to you? _____
_____
Do you have a secondary sound? _____

Do you have a third sound? _____
What percentage of time are you aware of your tinnitus? _____
What percentage of time are you disturbed by your tinnitus? _____
When is your best time of day? _____
When is your worst time of day? _____

Is there anything that makes your tinnitus better? _____
_____
Is there anything that makes your tinnitus worse? _____
_____
Do you feel that the tinnitus had made you alter your daily life? _____
Is there anything that you do not do because of your tinnitus? _____
_____
_____
Have you seen anyone previously regarding your tinnitus? If so what did they say? _____
Have you had either an MRI or ABR to evaluate your tinnitus? _____
What have you done to try to manage your tinnitus in the past? _____
_____
_____
Did you feel that your previous attempt was successful?_____
Attentional Reactive

DIZZINESS/LOSS OF BALANCE

Do you have a history of dizziness or balance problems?
NO YES
The dizziness or loss of balance is:
___ Constant
___ Episodic, "comes and goes"
___ Only upon movement
___ Accompanied by nausea
___ Other information _____

GENERAL DIFFICULTIES

Please circle all that apply:

Concentration	Conversation	Work	Falling asleep	Staying asleep
Restaurants	Social events	Religious	Exercise	Sports events
Activities in quiet	Reading	Movies	Super Market	

Other:				

MEDICAL HISTORY

Please circle all that apply:

Hearing loss	Noise induce HL	Cerumen / Ear Wax	Eust. tube disfunction	Middle ear difficulties
Sinus	TMJ	Grinding	Clenching	Acoustic neuroma
Tumor	Meniere's Disease	Ototoxic Medications	Surgery	Head trauma
Neck trauma	Back Injury	Auto Accident	Concussion	TBI
Migraines	Balance Problems	Depression	Therapy	Other:

NUTRITION

Please state if you "overindulge" in any of the following?

Salt _____

Sugar_____

Tonic Water_____

Caffeine_____

Nicotine _____

Alcohol _____

Asprin _____

Chocolate _____

Are you a smoker? _____

How many per day? _____

If you once were a smoker and have since have quit:

How long ago did you quit? _____

How many years did you smoke? _____

EXERCISE

Please explain What you currently are doing for exercise. _____

_____

_____

SLEEP

What time do you go to bed?_____

What time do you fall asleep? _____

How many times do you wake up at night? _____

Are you able to easily fall back to sleep if up during the night? _____

How long does it take you to fall back asleep? _____

What time do you wake up in the morning? _____

What time do you get out of bed in the morning? _____

Total hours of sleep per night (on average)? _____

PERSONAL HISTORY

Current Occupation _____

_____

_____

Prior Occupation _____

_____

_____

Family Members _____

_____

_____

Personality Type _____

Other _____

_____

_____

OTHER INFORMATION YOU WOULD LIKE TO SHARE

_____

_____

_____

IF YOU HAVE HAD ANY TESTING WITHIN THE PAST YEAR SUCH AS A HEARING TEST, MRI OR CT SCAN OF THE HEAD, PLEASE BRING THE RESULTS WITH YOU TO YOUR APPOINTMENT.

TINNITUS REACTION QUESTIONNAIRE – TRQ

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that **best** reflects how your tinnitus has affected you **over the past week**.

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has “driven me crazy”.	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4

22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
Total					