



Elena L. Maresca Au.D.
Hearing and Tinnitus Management
207 Hallock Road, Suite 208
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(631) 780-HEAR
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Please answer the following questions prior to your appointment.

Please bring the completed information packet with you to your Evaluation Appointment, which is scheduled as follows:

If you need more space for your answer, please continue on the back of the questionnaire and indicate the question number.



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PATIENT INFORMATION

DATE _____

NAME Dr. Mr. Mrs. Ms. Miss. _____

ADDRESS _____

DATE OF BIRTH _____

OCCUPATION _____

HOME PHONE # _____

CELL PHONE # _____

MAY WE LEAVE A MESSAGE? _____

SECONDARY CONTACT _____

RELATIONSHIP TO PATIENT _____

MAY WE DISCUSS CASE WITH SECONDARY CONTACT? _____

PRIMARY CARE PHYSICIAN _____

EAR NOSE & THROAT PHYSICIAN _____

REFERRING PHYSICIAN _____

HOW DID YOU HEAR OF OUR PRACTICE _____



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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 Sensitivity

___ 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 dysfunction	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 _____
- Aspirin _____
- 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.**