



HEARING SOLUTIONS IN THE TRIANGLE, PLLC

NAME: _____ DATE: _____

ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____ CELL: _____

E-MAIL ADDRESS: _____ DATE OF BIRTH: _____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

EMPLOYER: _____

TINNITUS DESCRIPTION AND HISTORY

1. When did you become aware of having TINNITUS (noise or sounds in your ears or head)?

2. Did you become aware of your TINNITUS suddenly or gradually?

3. Before that did you experience any episodes of temporary or milder tinnitus? ___yes ___no

If yes: (check all that apply in the list below:

___ After exposure to loud sound ___ Associated with colds, flu or allergy problem

___ Any other time(s): _____

(Describe)

4. How long has TINNITUS been a significant problem: _____

5. Were illnesses, accident or other special circumstances associated with the onset of your present TINNITUS?

(Please explain briefly)

6. Does your TINNITUS consist of ONE sound or MORE than one sound? _____

7. In the list below, please check sound(s) that most closely resemble your tinnitus:

___ Ringing ___ Hissing ___ Sizzling ___ Pulsating ___ Clear Tone ___ Buzzing ___ Pounding

___ Hum ___ Whistle ___ Music ___ Clicking ___ Transformer Noise

___ High Tension Wire ___ Crickets, Insects ___ Other: _____

(Describe)

Has your TINNITUS sounded about the same (in terms of the TYPE of sound) since it first started, or has the type of sound changed? _____

(Describe change(s) if any)

(Name) _____

8. If you hear MORE than one sound, which sound is predominant or most bothersome?

9. Where does your PREDOMINANT TINNITUS sound appear to be coming from?

If in more than one location, where is it worst: _____

10. If you do hear other TINNITUS sounds besides the predominant one, please describe:

<u>Type of Sound</u>	<u>Location</u>
Sound #2 is: _____,	Appears to be located in: _____
Sound #3 is _____	Appears to be located in: _____
Do you hear any additional sounds not already described? <input type="checkbox"/> NO <input type="checkbox"/> YES	

(Indicate type of sound and where located)

11. Do you hear your PREDOMINANT TINNITUS sound all the time or is it sometimes absent?

Heard all the time Sometimes absent: _____
(Approximate percent of time heard)

Since your TINNITUS started, has it altered in regard to the percent of time heard?

No change Yes, percent of time has changed Not sure

If YES: I now hear TINNITUS MORE of the time than at first I now hear TINNITUS LESS of the time

12. Since it started has the LOCATION of your TINNITUS changed? NO YES

If YES: Please describe changes: _____
Were changes related to illness, accident, or other event?

(Please describe briefly)

13. Since it started has the LOUDNESS of your TINNITUS changed? NO YES

If YES: Has it become: louder softer both types of change occurred
Were changes related to illness, accident or other event?

(If yes, describe briefly)

14. Does the LOUDNESS of your TINNITUS tend to fluctuate up and down? NO YES

If YES: Indicate size of fluctuations: barely noticeable moderate very marked variable
How often do fluctuations occur: daily several per week several per month rarely

15. On the scale below please indicate the loudness of your USUAL TINNITUS: (circle number)

0 1 2 3 4 5 6 7 8 9 10

16. Have you noticed changes in TINNITUS LOUDNESS caused by any of the following: (check all that apply and indicate whether they make TINNITUS louder or softer)

<input type="checkbox"/> Tobacco use	_____	<input type="checkbox"/> Alcoholic beverages	_____
<input type="checkbox"/> Marijuana	_____	<input type="checkbox"/> Aspirin	_____
<input type="checkbox"/> Tylenol, other pain killers	_____	<input type="checkbox"/> Caffeine (coffee, tea, cola, etc)	_____
<input type="checkbox"/> No, none of the above alters my tinnitus			

(Name) _____

17. Have you noticed changes in TINNITUS LOUDNESS caused by any of the following: (check all that apply and indicate whether they make TINNITUS louder or softer)

- | | | | |
|---|-------|---|-------|
| <input type="checkbox"/> Noise exposure | _____ | <input type="checkbox"/> Stress or Fatigue | _____ |
| <input type="checkbox"/> Colds, Sinus, Allergies | _____ | <input type="checkbox"/> Coughing or Sneezing | _____ |
| <input type="checkbox"/> Moving Jaw, Clenching Teeth | _____ | <input type="checkbox"/> Changes in Altitude | _____ |
| <input type="checkbox"/> Alterations in Body Position | _____ | | |
| <input type="checkbox"/> No, none of the above alters my TINNITUS | | | |

18. Is there anything else that you have noticed causes changes in your TINNITUS?

(Indicate agent causing change)

(Indicate nature of change)

19. Does your TINNITUS interfere with sleep? NO Yes, sometimes Yes, often
If YES: Type of interference: Trouble getting to sleep Trouble staying asleep Other
How severe if problem: Mild Moderate Severe
Have you found anything that helps you sleep: _____

(Describe)

20. Do you feel TINNITUS has caused you significant problems in any of these ways:

- | | | | |
|-------------------------------------|-----------------------------|------------------------------------|------------------------------|
| Makes you feel irritable or nervous | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Yes |
| Makes you feel tired or ill | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Yes |
| Makes it difficult to relax | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Yes |

21. Has TINNITUS caused you any of the following problems:

- | | | | |
|---------------------------------------|-----------------------------|------------------------------------|------------------------------|
| Made it uncomfortable to be in quiet | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Yes |
| Made it difficult to concentrate | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Yes |
| Made it harder to interact pleasantly | <input type="checkbox"/> No | <input type="checkbox"/> Sometimes | <input type="checkbox"/> Yes |

22. Any other problems TINNITUS has caused you:

(A) At work: _____
(Describe problem)

(B) At home or in leisure time: _____
(Describe problem)

23. Have you changed jobs because of TINNITUS? NO YES

(Explain change)

24. Have you made other significant changes in your lifestyle because of TINNITUS? NO YES

(Explain)

25. How much of an effort is it for you to ignore your TINNITUS when it is present?

- | | |
|--|---|
| <input type="checkbox"/> No discomfort | <input type="checkbox"/> Moderate discomfort |
| <input type="checkbox"/> Mild discomfort | <input type="checkbox"/> A great deal of discomfort |

(Name)

26. How much discomfort do you usually experience when your tinnitus is present?

- No discomfort Moderate discomfort
 Mild discomfort A great deal of discomfort

27. How much interference does TINNITUS cause you for the following activities?

	None	Slight	Moderate	A Great Deal
A. Work Activities	_____	_____	_____	_____
B. Social Activities	_____	_____	_____	_____
C. Overall Enjoyment	_____	_____	_____	_____

28. Have you previously sought medical help for your tinnitus? NO YES

(If yes, please indicate where and when)

29. Have you previously tried any of the following types of treatment for TINNITUS? (place Y or N next to treatment)

	Dates	Amount of Relief
<input type="checkbox"/> Biofeedback	_____	_____
<input type="checkbox"/> Drug Therapy: _____	_____	_____
<input type="checkbox"/> Masking	_____	_____
<input type="checkbox"/> Hypnosis or Acupuncture	_____	_____
<input type="checkbox"/> Other: _____ (Describe)	_____	_____