SHOHET EAR ASSOCIATES
MEDICAL GROUP, INC.

TINNITUS/HYPERACUSIS HISTORY

Name:_____ DOB: _____ Age: _____
Referred by: _____ Date: _____

TINNITUS (head noise or ear sounds)

1. Please describe your tinnitus: _____
   _____
   _____
   _____
2. Where is your tinnitus located? (circle one)
   right ear left ear both ears not in ears head
3. If your tinnitus is in both ears, is one side louder than the other?
4. When did you first become aware of having tinnitus?_____
   _____
   _____
5. Was onset: (circle one) gradual sudden
6. Is it intermittent or constant? (circle one) intermittent constant
7. Does your tinnitus fluctuate in volume? (circle) Yes / No
8. Is the volume of the tinnitus stable, or does it change?_____
9. Is it a pulsing sound that changes in time with your heartbeat?_____
10. Estimate the percentage of time over the past month that you have been aware of the tinnitus. _____
11. What seems to make the tinnitus change?_____
    _____
    _____
12. When you have your tinnitus, which of the following makes it WORSE: (circle all that apply)
    a. alcohol
    b. being in a noisy place
    c. being in a quiet place
    d. changing head position
    e. coffee/tea
    f. constipation
    g. during menstrual period
    h. drugs/medicine
    i. emotional or mental stress
    j. food (please specify):
    k. wearing a hearing aid
    l. lack of sleep
    m. relaxation
    n. shooting guns, rifles, etc.
    o. smoking
    p. sudden physical activity
    q. when you are excited
    r. when you are tired from physical work
    s. when you wake up in morning
    t. nothing makes it worse
    u. other (please specify):
13. Which of the following REDUCES your tinnitus? (circle all that apply)
    a. alcohol
    b. being in a noisy place
    c. being in a quiet place
    d. coffee/tea
    e. drugs/medicine
    f. food (please specify):
    g. listening to TV/radio
    h. sleep
    i. smoking
    j. nothing reduces it
    k. wearing a hearing aid
    l. other (please specify):

14. List all methods, procedures, medications, or devices you have tried for your tinnitus as well as treatment outcomes:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

15. I am concerned that my tinnitus is a symptom of a much worse disease. Yes / No
16. I am concerned that I may go deaf because of my tinnitus. (circle) Yes / No
17. Have you seen ear specialists about your tinnitus? (circle) Yes / No
    How many? _____
    What were you told? _____
    _____
    _____
    _____
    _____
    _____
    _____

HYPERACUSIS (hypersensitivity to external sounds)

1. Do you experience physical ear discomfort from loud sounds? (circle) Yes / No
2. When were you first aware of this problem? _____
   _____
   _____
   _____
3. What seems to make the hyperacusis change? _____
   _____
   _____
4. Is it made worse by exposure to a sound? _____
5. Are you uncomfortable around certain sounds? _____
6. Do you wear ear protection devices (plugs/muffs)? If so, what percentage of time do you wear them?_____
7. Do you wear ear protection in quiet situations? _____
8. Have you ever had a job/hobby that exposed you to loud sounds? _____
   _____
9. Estimate the percentage of time over a month period (not counting sleeping) when you are:
   a. in a quiet environment (i.e. quiet home) _____%
   b. in a moderate level of noise (i.e. street, office, restaurant) _____%
   c. in a loud environment (i.e. noisy work place, loud radio/TV) _____%
10. Do you feel depressed? If so, why? _____
    _____
    _____
    _____

11. Did you have depression or anxiety before the onset of tinnitus or hyperacusis? If so, when? _____
_____
_____
_____

12. What medications are you currently taking, and what is each used for?

Name of the drug *example: Aspirin*	Dose *325 mg / 1 per day*	Use *headaches*

13. Are there activities that you are prevented from doing, or that are affected by the tinnitus/hyperacusis? (indicate with an "X" in the areas below)

Activity	Tinnitus			Hyperacusis		
	Yes	No	Not Sure	Yes	No	Not Sure
Concentration	_____	_____	_____	_____	_____	_____
Falling Asleep	_____	_____	_____	_____	_____	_____
Staying Asleep	_____	_____	_____	_____	_____	_____
Restaurants	_____	_____	_____	_____	_____	_____
Social Events	_____	_____	_____	_____	_____	_____
Church	_____	_____	_____	_____	_____	_____
Sporting Events	_____	_____	_____	_____	_____	_____
Quiet Activities	_____	_____	_____	_____	_____	_____
Concerts	_____	_____	_____	_____	_____	_____
Other	_____	_____	_____	_____	_____	_____

14. Do you have legal action pending, or are you planning legal action in relation to your tinnitus/hyperacusis?
15. On a scale of 0-10 (0=none, 10=totally ruined), indicate the influence tinnitus and hyperacusis have on your life.

HEARING LOSS

1. Are you aware of any hearing loss? If so, please describe. _____
_____
_____
_____

2. How long have you had a hearing loss? _____

3. Was onset: (circle one) gradual sudden
4. Do you currently wear, or have you ever worn hearing aid(s)? _____
   _____
   _____

5. Have you had previous ear surgery? If so, please explain. _____
   _____
   _____
   _____
   _____
   _____

6. Do you have a family history of hearing loss, tinnitus, hyperacusis, vertigo? If so, please explain. _____
   _____
   _____
   _____
   _____

7. Have you had fullness in your ear(s) in the past 3 months? Yes / No

8. Have you had ear pain in your ear(s) in the past 3 months? Yes / No

9. Have your ear(s) been draining in the past 3 months? Yes / No

10. Do you have history of your ear(s) being plugged with wax? Yes/ No

11. Do you have skin allergies to soap or perfume? Yes / No

12. Have you ever had a serious infection requiring intravenous antibiotics? Yes / No

13. Rank (indicate by number) how much these concern you (1=most, 3=least)
    _____ tinnitus _____ hyperacusis _____ hearing loss

OTHER

1. Do you have history of: (circle all that apply)
   a. circulation problems
   b. diabetes
   c. glaucoma
   d. heart disorder
   e. hepatitis
   f. hypertension
   g. kidney disease
   h. seizures
   i. stroke
   j. thyroid disorder
   k. other:

2. List other sources of stress: (i.e. job, family, health): _____
   _____
   _____
   _____
   _____

3. Are you under the care of a psychologist/psychiatrist within the past year? Yes/No