



TINNITUS & HYPERACUSIS
Patient Questionnaire

Name: _____ **DOB:** _____ **Age:** _____

1. 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 head
4. If your tinnitus is in both ears, is one side louder than the other? yes no
5. What does your tinnitus sound like (for example: ringing, cricket, humming, etc.)?
6. Is the volume of tinnitus stable, or does it change?
 Is it a pulsing sound that changes in time with your heart beat? yes no
7. What seems to make the tinnitus/hyperacusis change?
8. Is it made worse by exposure to sound? yes no
 If yes, how long does it stay bad after sound exposure?
9. List all methods, procedures, medications, or devices you have tried for your tinnitus, and the treatment outcomes (include an additional sheet if you want).

10. Have you seen an ear specialist about your tinnitus? yes no How many?
 What were you told?

11. Do you have a hearing loss? yes no
 If yes, please describe?

12. Do you wear hearing aids? yes no

13. Are you uncomfortable with certain sounds? yes no

14. Do you wear ear protection (plugs or muffs)? yes no

If yes, what percentage of time do you wear them?

15. Do you wear ear protection in quiet situations? yes no

16. Do you experience pain in the ears from loud sounds? yes no

17. Have you ever worked anywhere that exposed you to continuous loud noise? yes no

18. Estimate the percentage of time over the past month that you have been aware of the tinnitus?

19. Estimate the percentage of time over a month period (not counting sleep) when you are:

a) in a quiet 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, very loud TV/radio) ____%

20. Are there activities that you are prevented from doing, or that are affected by the

tinnitus/hyperacusis? yes no

Tinnitus

Hyperacusis

Activity:

Concentration yes no not sure

yes no not sure

Falling asleep yes no not sure

yes no not sure

Staying asleep yes no not sure

yes no not sure

Restaurants 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 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? yes no

If yes, please explain why?

22. Did you have any depression or anxiety before the onset of tinnitus or hyperacusis? yes no

If yes, when?

23. What medications are you currently taking? 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 any legal action? yes no

25. On a 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 concerns you (1=most and 3=least):

____ tinnitus _____ hyperacusis _____ hearing loss

27. Please write below any other information related to your tinnitus or hyperacusis.