Twin Rivers
Hearing Health, Inc.
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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 your 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.