HEARING
LISTENING
TINNITUS
HYPERACUSIS

SOUND id·EARS CLINIC

TINNITUS AND HYPERACUSIS QUESTIONNAIRE

Name:	Date:

INSTRUCTIONS: Please answer the following questions. If you need more space for your answer, please continue on a separate sheet.

1. When did you first become aware of having tinnitus and/or hyperacusis (increased sensitivity to sound), and what do you believe caused these symptoms?

2. Was the onset: --

3. Where is the primary location of your tinnitus?

-- /

4. What does the tinnitus sound like (ringing, hissing, humming, crickets, seashell, etc.)?

5. Is your tinnitus: --

6. Does your tinnitus fluctuate in volume? --

7. Is it pulsing in time with your heartbeat? --

8. Do you have "bad days"/ "tinnitus days"? --

How many days per week?

9. Does you tinnitus appear worse (check all applicable):

☐	When tired	☐	When tense or nervous
☐	At bedtime	☐	After use of alcohol
☐	Upon awakening	☐	When relaxed

10. How does sound effect your tinnitus? --

If so, how long does this effect last for? --

11. List all methods, procedures, medications, or devices you have tried for your tinnitus and the outcome of the treatments.

12. Have you seen other specialists about your tinnitus? How many? What were you told?

13. Why is the tinnitus a problem?

14. Estimate the percentage of time over the past month that you are:

Aware of your tinnitus: %
Annoyed by your tinnitus: %

15. Please circle, on a scale from 1 to 10 (where 0 = none, 10 = totally devastated):

	0					5					10
Severity of tinnitus:	○	○	○	○	○	○	○	○	○	○	○
Annoyance of tinnitus:	○	○	○	○	○	○	○	○	○	○	○
Effect of tinnitus on your life:	○	○	○	○	○	○	○	○	○	○	○

16. Do you have hearing loss? Describe.

17. Have you ever been recommended hearing aids? --

If yes, do you currently wear hearing aids? --

18. If you are a hearing aid user, how do they affect your tinnitus?

--

19. Are you over sensitive to sound? --

If yes, do you experience physical discomfort/pain around certain sounds? Yes

20. What kind of sounds/noises are troublesome to you?

21. Do you wear ear protection (plugs or muffs)? --

If so, estimate the percentage of time you wear them: %

Do you wear them in quiet situations? --

22. List all methods, procedures, medicines, or treatments you have tried for your hyperacusis:

23. Why is the sound sensitivity a problem?

24. Have you ever worked anywhere that exposed you to continuous loud noise such as a factory, jackhammer, airport, etc.? Yes

If so, where or what was it, and how long?

25. Please circle, on a scale from 1 to 10 (where 0 = none, 10 = totally devastated):

	0					5					10
Severity of hyperacusis:	○	○	○	○	○	○	○	○	○	○	○
Annoyance of hyperacusis:	○	○	○	○	○	○	○	○	○	○	○
Effect of hyperacusis on your life:	○	○	○	○	○	○	○	○	○	○	○

26. Do you have "bad" sound sensitivity days? --

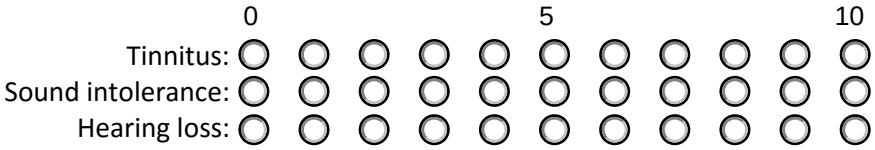
If yes, how many "bad" days per week?

27. Are there activities that you are prevented from doing, or that have been affected by the tinnitus/hyperacusis? (Check either Yes / No / Unsure)

	Tinnitus			**Hyperacusis**		
	Yes	**No**	**Unsure**	**Yes**	**No**	**Unsure**
Concentration	○	○	○			
Sleep	○	○	○			
Quiet Recreational Activities	○	○	○			
Work	○	○	○	○	○	○
Restaurants	○	○	○	○	○	○
Sports	○	○	○	○	○	○
Social Events	○	○	○	○	○	○
Concerts				○	○	○
Housekeeping				○	○	○
Shopping				○	○	○
Driving				○	○	○
Childcare				○	○	○
Movies				○	○	○
Church				○	○	○
Other (please explain)						

28. What medication are you currently taking and for what purpose?

29. Please rank how severely the following problems affect your life (where 0 = none, 10 = totally devastated):



30. Do you have legal action pending in relation to your tinnitus or hyperacusis, or are you planning legal action? --

If you have retained a lawyer in relation to your tinnitus, please list:

Lawyers' name:
Company:
Contact: