UW Speech and Hearing Clinic

UNIVERSITY OF WISCONSIN - MADISON
TINNITUS AND HYPERACUSIS PROGRAM

Goodnight Hall
1975 Willow Drive
Madison, WI 53706
Phone: 608-262-3951
https://csd.wisc.edu/tinnitus

Name: _____ **Date:** _____

Please contact your physician for a referral if any of the following apply to you: Symptoms of Meniere's disease, tinnitus that pulsates with your heartbeat (pulsatile tinnitus), ear drainage, ear pain, dizziness, newly onset tinnitus or hearing loss, progressive tinnitus, conductive hearing loss, hearing loss worse in one ear. **Please go to Emergency Care or a Mental Health Clinic if you experience the following:** Extreme anxiety or depression, a current plan to end your life or a way to do it. **Please go to Emergency Care or Ear, Nose, and Throat (ENT) immediately if you experience the following:** Injury to your body, weakness or paralysis of any muscles in your face, sudden unexplained hearing loss in one or both ears.

1. Do you have a hearing loss? ☐ No ☐ Yes ☐ Left ☐ Right ☐ Both
   If no, go to 6
2. What is the cause of your hearing loss? _____
3. What is the duration of your hearing loss? _____
4. Is your hearing changing? ☐ No ☐ Yes ☐ Progressive ☐ Fluctuating ☐ Stable
5. Do you use hearing aids? ☐ No ☐ Yes
   What is the make and model (if known)?_____
6. Do you have dizziness? ☐ No ☐ Yes
   Can you describe your dizziness without using the word dizzy?
   _____
   _____
7. Do you have a history of (if yes, please explain):

Ear infections	☐ No	Yes _____
Noise exposure	☐ No	Yes _____
Family history of hearing loss	☐ No	Yes _____
Family history of tinnitus	☐ No	Yes _____
Family history of sound tolerance	☐ No	Yes _____
Head trauma	☐ No	Yes _____
Ear surgery	☐ No	Yes _____
Explosive injuries to the ears	☐ No	Yes _____
Intravenous antibiotics	☐ No	Yes _____

8. Do you have problems with any of the following? If yes, please explain

Breathing, Respiratory System	☐ No	Yes _____
Heart, blood pressure	☐ No	Yes _____
Digestive system	☐ No	Yes _____
Urinary tract/kidney	☐ No	Yes _____
Reproductive system	☐ No	Yes _____
Bone & Joint	☐ No	Yes _____

Diabetes or thyroid	☐ No	Yes	_____
Skin problems	☐ No	Yes	_____
Neurologic, headaches, migraines	☐ No	Yes	_____
Infections	☐ No	Yes	_____
General (weight loss, fever)	☐ No	Yes	_____
Anxiety or psychological	☐ No	Yes	_____
Change in appetite	☐ No	Yes	_____
Sleep disorder	☐ No	Yes	_____
No energy, often fatigue	☐ No	Yes	_____
Restless and irritable	☐ No	Yes	_____
Feeling of worthless, hopeless	☐ No	Yes	_____
Difficulty thinking, concentrating	☐ No	Yes	_____
Thought of death	☐ No	Yes	_____
Attempts of suicide	☐ No	Yes	_____
Pessimistic about life goals	☐ No	Yes	_____
Chronic aches and pains	☐ No	Yes	_____

9. List <u>all</u> current medications and doses (Please PRINT):

Name of the drug *example: Aspirin*	Dose *example: 325 mg/ 1 per day*	How Long *Example: last 2 years*
1.		
2.		
3.		
4.		
5.		
6.		

Indicate medication allergies: None ☐ List _____

Tinnitus & Decreased Sound Tolerance Questions

1. When did you first become aware of having Tinnitus? (If you don't have Tinnitus, skip to question 12).

2. In which ear is your Tinnitus? (right, left, both, not in ears, in head)

3. If Tinnitus is in both ears, is one side louder than the other? Right or Left?

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

5. Is the volume of Tinnitus stable, or does it change?

6. Is your Tinnitus pulsing or rhythmic?

7. Is your Tinnitus synchronized with your heartbeat?

8. Does anything seem to make Tinnitus change (if yes, please explain).

9. Is the Tinnitus made worse by exposure to a sound? If so, how long does it stay worse after the exposure?

10. List all methods, procedures, medications, or devices you have tried for your Tinnitus and the treatment outcome.

11. Have you seen other ear specialists about your Tinnitus? What were you told?

What tests were done?

Audiogram	☐ No	☐ Yes	Date(s): _____
ABR	☐ No	☐ Yes	Date(s): _____
CT scan	☐ No	☐ Yes	Date(s): _____
MRI	☐ No	☐ Yes	Date(s): _____
ENG/VNG	☐ No	☐ Yes	Date(s): _____
Other	☐ No	☐ Yes	Date(s): _____

12. Is your tolerance to LOUDER sounds the same as of people around you? ☐ No ☐ Yes
    If no, when did it start?

13. Is your tolerance to SPECIFIC sounds the same as of people around you? ☐ No ☐ Yes
    List uncomfortable sounds:

14. List all methods, procedures, medications, or devices you have tried for your decreased sound tolerance and the treatment outcome.

15. Have you seen other ear specialists about your decrease sound tolerance? What were you told?

16. Did you have any depression or anxiety before the onset of tinnitus or decreased sound tolerance?
    ☐ No ☐ Yes If yes, when?

17. Do you have legal action pending in relation to your tinnitus/sound tolerance, or are you planning legal action? ☐ No ☐ Yes

18. On a scale from 0 to 10 (0 = none; 10 = as bad as you can imagine), please indicate the influence of tinnitus, sound tolerance, and/or hearing loss has on your life.

Tinnitus	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Sound Tolerance	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10
Hearing Loss	☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10

19. What is the greatest concern for you? ☐ Tinnitus ☐ Sound Tolerance ☐ Hearing Loss

20. Please make a list of all the problems you have as a result of your tinnitus and/or sound tolerance.