Calgary Ear Centre

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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)?

2. Where is your tinnitus primarily located? Explain.

Right ear / Left ear / Both ears equal / In your head / Other _____

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

4. The loudness of your tinnitus is (check one):

	Fairly constant from day to day
	Fluctuates widely, being very loud some days and very mild other days
	Usually constant, but occasionally decreases markedly
	Usually constant, but occasionally increase markedly

5. Is it a pulsing sound that beats in time with your heartbeat? Yes / No

6. What seems to make the tinnitus/hyperacusis change?

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

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

8. Is it made worse by exposure to a sound? If so, 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 outcome of the treatments.

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

11. Is there any time during the day when your tinnitus is most troublesome to you?

	At work		In the morning
	In the evening		When trying to concentrate
	At social activities		Around noise
Other:			

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

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

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

Severity of tinnitus: 0 1 2 3 4 5 6 7 8 9 10
Annoyance of tinnitus: 0 1 2 3 4 5 6 7 8 9 10
Effect of tinnitus on your life: 0 1 2 3 4 5 6 7 8 9 10

14. Do you have hearing loss? Describe.
15. Have you ever worn a hearing aid? Yes / No **If yes, do you currently wear them?** Yes / No
16. If you are a hearing aid user, how do they affect your tinnitus? Makes tinnitus softer / Makes tinnitus louder / No effect
17. Are you uncomfortable around certain sounds? Yes / No
18. What kind of sounds/noise are you sensitive to?
19. Do you avoid any activities or environments because of noise? Describe:
20. Do you wear ear protection (plugs or muffs)? Yes / No **If so, estimate the percentage of time you wear them:** % **Do you wear them in quiet situations?** Yes / No
21. Do you experience pain in the ears from loud noises?

22. Have you ever worked anywhere that exposed you to continuous loud noise such as a factory, jackhammer, airport, etc.? If so, how long?

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

Severity of hyperacusis:	0	1	2	3	4	5	6	7	8	9	10
Annoyance of hyperacusis:	0	1	2	3	4	5	6	7	8	9	10
Effect of hyperacusis on your life:	0	1	2	3	4	5	6	7	8	9	10

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

	TINNITUS			HYPERACUSIS		
ACTIVITY	*YES*	*NO*	*UNSURE*	*YES*	*NO*	*UNSURE*
Concentration						
Falling asleep						
Staying asleep						
Restaurants						
Social Events						
Church						
Sports Events						
Quiet recreation (reading, playing cards)						
Concerts						
Other (specify)						

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

26. Do you have legal action pending in relation to your tinnitus or hyperacusis, or are you planning legal action? Yes / No

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

Lawyers's name:
Company:
Contact:

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

Tinnitus:	0	1	2	3	4	5	6	7	8	9	10
Sound intolerance:	0	1	2	3	4	5	6	7	8	9	10
Hearing loss:	0	1	2	3	4	5	6	7	8	9	10

28. Please NOTE any other information you may feel is relevant to your tinnitus or hyperacusis: