

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
HYPERACUSIS NEW PATIENT INFORMATION FORM

NAME: _____ AGE: _____ DATE: ___/___/___
REFERRED BY: _____ DAYTIME PHONE: _____ HOME PHONE: _____

- When did you first experience hyperacusis? _____
- How long have you had hyperacusis in its present form?
_____ years _____ months
- Briefly describe what you were doing when the hyperacusis first became apparent to you.

- Were you experiencing any kind of emotional trauma at the time when you first noticed your hyperacusis? _____
- What do you think is the cause of your hyperacusis?

- Where is your hyperacusis primarily located?
_____ left ear _____ right ear _____ both ears equally
other (please explain) _____
- List some sounds you find excessively loud?

- Do you find normal conversation to be excessively loud?

- The sensitivity of your hyperacusis 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 increases markedly

- Does your hyperacusis appear worse:
_____ when tired? _____ when tense or nervous?
_____ at bedtime? _____ after use of alcohol?
_____ upon awakening? _____ when relaxed?

- Is there any time during the day when your hyperacusis is most troublesome to you?
_____ at work _____ in morning
_____ in evening _____ when trying to concentrate
_____ at social activities _____ around noise
Other: _____

- How many times are you bothered by your hyperacusis in an average day? _____
- Do you consider yourself to be a tense person? _____

- Do you feel that emotional or physical stress worsens the hyperacusis? _____.

- ***PLEASE TELL US HOW YOUR HYPERACUSIS INTERFERES WITH YOUR ACTIVITIES:**

Concentration _____

Work/Chores _____

Family _____

Religious Activities _____

Social/Recreation _____

Exercise _____

Sleep _____

- Does the hyperacusis prevent you from falling asleep? _____

- Does the hyperacusis awaken you from sleep? _____

- Are you able to fall back asleep, once awakened? _____

Other _____

- Do you have a hearing loss? ____ yes ____ no

- *Which is more of a problem for you, the hearing difficulty or your hyperacusis?

____ hearing difficulty ____ hyperacusis ____ not sure

- Have you been exposed to loud noise? ____ yes ____ no

If so, when: ____ military service ____ work ____ recreation

____ other: _____

- Do you wear ear protection in the presence of loud sounds?

____ yes ____ no

- How often do you wear ear protection? _____

- Have you ever worn a hearing aid? ____ yes ____ no

If yes, do you currently wear it (them)? ____ yes ____ no

- Do you have tinnitus?

If yes, in which ear(s)? _____

- How would your life be different if you didn't have hyperacusis?

- Have you discussed your hyperacusis with friends or family members? _____

What was their reaction? _____

- Are there other members of your family, or friends who suffer from hyperacusis? _____

- Do you live alone? _____

TREATMENT HISTORY:

- Please list all evaluations and/or treatments (including psychiatric or psychological) you have had for your hyperacusis. Please include the names of the specialists who have performed evaluations or treatments, and the approximate dates on which they were performed, using the reverse side, if necessary.

<u>Provider</u>	<u>Date</u>	<u>What was done</u>	<u>Result</u>
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

- Please list any surgeries you have had (potentially related to your current symptom of hyperacusis)
- _____
- _____
- _____

- Please list all medications you currently take:

<u>Medication</u>	<u>Dose</u>	<u>How often?</u>	<u>Purpose?</u>	<u>Doctor</u>
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

- Using the number codes below, please indicate the results of those treatments you have tried for your hyperacusis. If you have not tried a given treatment, please place an "NA" in the blank for that treatment.

1 = Major relief 2 = Some relief 3 = No relief 4 = Some relief with bad side effects 5 = Hyperacusis worse
 NA = Not applicable, treatment not tried

- | | |
|----------------------|--|
| ____Surgery | ____Acupuncture |
| ____Drug Therapy | ____Massage |
| ____Hearing aids | ____Homeopathy |
| ____Masking therapy | ____Biofeedback |
| ____Physical therapy | ____Chiropractic |
| ____Antidepressants | ____Relaxation training or hypnosis |
| ____Exercise program | ____Psychotherapy or other counseling |
| ____Dental | ____Dietary Management or nutrition counseling |
| ____Other _____ | |

- Are you employed? _____ # of hours/week _____
- What is your occupation? _____
- Are you satisfied? _____
- If not employed, is your unemployment due to hyperacusis? _____

• **CHECKLIST OF PROBLEMS** (Please check all items you feel are applicable to you):

- poor health for much of your life
- history of middle ear disease
- history of Meniere's disease
- history of otosclerosis
- history of facial pain/numbness or paralysis
- history of labyrinthitis
- history of mastoiditis
- history of ear surgery
- history of ear surgery
- migraine headaches
- hyperventilation syndrome
- hypertension (high blood pressure)
- cancer
- dizziness/imbalance or vertigo
- arthritis
- heart disease
- depression
- increased use of alcohol or drugs
- fair to poor dietary habits
- moderate to excessive use of caffeine substances (cola, coffee, chocolate)
- low back pain
- whiplash or neck injury
- hyperacusis is altered by change in position
- stiffness or reduced mobility of the neck
- limitations and/or pain when moving head
- significant headaches
- headaches that change with head movement
- tenderness/pain in the jaw area with or without chewing
- clenching or grinding of teeth
- limitation and/or pain with mouth opening or movement side to side
- history of clicking/locking/popping of the jaw
- personal or family history of diabetes/alcoholism/hypoglycemia (circle)
- personal or family history of hyperthyroid, hypothyroid or auto immune disease
- personal or family history of any type of hyperlipidemia
- personal or family history of inhalant or food allergies
- history of Epstein Barr-virus, cytomegalovirus or hepatitis (circle)
- history of excessive X-ray exposure around the head and neck
- poor thyroid or parathyroid function

- DO YOU HAVE LEGAL ACTION PENDING IN RELATION TO YOUR HYPERACUSIS?
____ yes ____ no

- IF NOT, ARE YOU PLANNING LEGAL ACTION?
____ yes ____ no

- WHAT IS THE NATURE OF THIS LEGAL ACTION?
() personal injury () workers comp () liability
Please explain _____

- IF YOU HAVE RETAINED AN ATTORNEY IN RELATION TO YOUR HYPERACUSIS, PLEASE LIST:

Attorney's name: _____
Phone #: _____ Address _____
City _____ State _____ Zip _____

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