

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Today's Date \_\_\_\_\_ Referred By \_\_\_\_\_

Daytime Phone \_\_\_\_\_ Home Phone \_\_\_\_\_

**When did you first experience tinnitus?**  
\_\_\_\_\_

**How long have you had tinnitus in its present form?** \_\_\_\_\_ Years \_\_\_\_\_ Months

**Briefly describe what you were doing when the tinnitus first became apparent to you.**  
\_\_\_\_\_  
\_\_\_\_\_

**Were you experiencing any kind of emotional trauma at the time when you first noticed your tinnitus?**  
\_\_\_\_\_

**What do you think is the cause of the tinnitus?**  
\_\_\_\_\_  
\_\_\_\_\_

**Where is your tinnitus primarily located?**  
 Left ear       Right ear       Both ears equally       Head  
Other (please explain): \_\_\_\_\_

**Using the scale below, indicate the loudness of:**  
\_\_\_\_ Your tinnitus right now  
\_\_\_\_ Your average tinnitus  
\_\_\_\_ Your tinnitus at its worst  
\_\_\_\_ Your tinnitus at its least

0	1	2	3	4	5	6	7	8	9	10
None	Mild		Moderate			Severe		Excruciating		

**Using the scale below, indicate the pitch of your tinnitus.** *It might help to imagine the scale as if it were a piano keyboard.*

0	1	2	3	4	5	6	7	8	9	10
Low pitch			Mid Pitch				High pitch			

**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 increases markedly

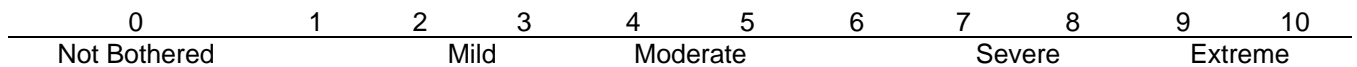
**Does your tinnitus appear worse (check all that apply):**

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

**Check all items below that describe the sound of your tinnitus:**

- Hissing
- Ringing
- Cricket-like
- Whistle
- Steam whistle
- Pounding
- Pulsating
- Bells
- Clanging
- Buzzing
- Sizzling
- Clicking
- Ocean roar
- High tension wire
- Other: \_\_\_\_\_

**To what extent are you bothered or annoyed by your tinnitus?**



**When are you aware of your tinnitus?**

\_\_\_\_\_

**What percentage of the time are you bothered by your tinnitus?**

\_\_\_\_\_

**Is there a time of day when your tinnitus is most troublesome to you?**

- At work
- In morning
- In evening
- When trying to concentrate
- At social activities
- Around noise

Other: \_\_\_\_\_

**Do you consider yourself to be a tense person?**

\_\_\_\_\_

**Do you feel that emotional or physical stress worsens the tinnitus?**

\_\_\_\_\_

**How does your tinnitus interfere with your activities?:**

Concentration: \_\_\_\_\_

Work/Chores: \_\_\_\_\_

Family: \_\_\_\_\_

Religious Activities: \_\_\_\_\_

Social/Recreation: \_\_\_\_\_

Exercise: \_\_\_\_\_

Sleep: \_\_\_\_\_

Does the tinnitus prevent you from falling asleep? \_\_\_\_\_

Does the tinnitus 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 tinnitus?**  
\_\_\_\_\_ Hearing difficulty                    \_\_\_\_\_ Tinnitus                    \_\_\_\_\_ 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

If yes, 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

**If you are a hearing aid user, how does the hearing aid affect your tinnitus?**  
\_\_\_\_\_ Makes tinnitus softer                    \_\_\_\_\_ Makes tinnitus louder                    \_\_\_\_\_ No effect

**Are you adversely affected by loud sounds?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No  
Please explain: \_\_\_\_\_

**How would your life be different if you didn't have tinnitus?**  
\_\_\_\_\_

**Have you discussed your tinnitus with friends or family members?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No  
What was their reaction? \_\_\_\_\_

**Are there other family members or friends who suffer from tinnitus?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

**Do you live alone?**                    \_\_\_\_\_ Yes                    \_\_\_\_\_ No

**TREATMENT HISTORY:**

Please list all evaluations and/or treatments (including psychiatric, psychological, MRI, CT scan, etc.) you have had for your tinnitus. 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.

	Provider	What was done?	Date	Result
1.				
2.				
3.				
4.				
5.				

Please list any surgeries you have had (potentially related to your current symptom of tinnitus):

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Please list all medications you currently take for tinnitus:

Medication	Dose	How often?	Does it help?	Doctor

What other medications have you tried in the past for tinnitus relief?

Medication	Dose	How often?	Did it help?	Stopped (Why)?

Please list all other medications you currently take:

Medication	Dose	How often?	Purpose?	Doctor

Using the number codes below, please indicate the results of those treatments you have tried for your tinnitus. 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 = Tinnitus worse; NA = Not applicable, treatment not tried**

- |   |   |
|---|---|
| <input type="checkbox"/> Surgery          | <input type="checkbox"/> Acupuncture                                |
| <input type="checkbox"/> Drug Therapy     | <input type="checkbox"/> Massage                                    |
| <input type="checkbox"/> Hearing aids     | <input type="checkbox"/> Homeopathy                                 |
| <input type="checkbox"/> Masking therapy  | <input type="checkbox"/> Biofeedback                                |
| <input type="checkbox"/> Physical therapy | <input type="checkbox"/> Chiropractic                               |
| <input type="checkbox"/> Antidepressants  | <input type="checkbox"/> Relaxation training or hypnosis            |
| <input type="checkbox"/> Exercise program | <input type="checkbox"/> Psychotherapy or other counseling          |
| <input type="checkbox"/> Dental           | <input type="checkbox"/> Dietary Management or nutrition counseling |
| <input type="checkbox"/> Other: _____     |   |

**Are you employed?**  Yes  No

Number of hours per week \_\_\_\_\_

What is your occupation? \_\_\_\_\_

Are you satisfied? \_\_\_\_\_

If not employed, is your unemployment due to tinnitus? \_\_\_\_\_

**Please check all items that 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
- 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
- Tinnitus 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 autoimmune 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
- Lyme disease

**Do you have legal action pending in relation to your tinnitus?**       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 tinnitus, please indicate:**

Attorney's name: \_\_\_\_\_  
 Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

**I authorize the release of all information in my UCSF Audiology Chart to the following individuals:**

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_