UCSF Medical Center

AUDIOLOGY CLINIC

HYPERACUSIS NEW PATIENT FORM

Name **Date of Birth** **Age**

Today's 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 the hyperacusis?

Where is the 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 (check all that apply):
_____When tired
_____When tense or nervous
_____At bedtime
_____After use of alcohol
_____Upon awakening
_____When relaxed

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Is there a time of 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:____

Do you consider yourself to be a tense person?

____

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

____

How does your hyperacusis interfere 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

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

Do you have tinnitus? _____Yes _____No

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? _____Yes _____No

What was their reaction?______________________________

Are there other family members or friends who suffer from hyperacusis? _____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 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.

	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 hyperacusis):

____
____
____
____

Please list all 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 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
____Drug Therapy
____Hearing aids
____Masking therapy
____Physical therapy
____Antidepressants

_____Acupuncture
_____Massage
_____Homeopathy
_____Biofeedback
_____Chiropractic
_____Relaxation training or hypnosis

____Exercise program _____Psychotherapy or other counseling
____Dental _____Dietary Management or nutrition counseling
____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 hyperacusis?____

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 labrynthitis
_____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
_____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 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 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 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: ______________________________