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

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: _____

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