

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

**Please fill both sides of this page**

1. What brings you here today? ( Chief complaint) \_\_\_\_\_

2. Have you ever had your hearing tested before?  Yes  No

**If yes**, when and where? \_\_\_\_\_

What were the results? \_\_\_\_\_

3. Do you think you have a hearing problem?  Yes  No

**If yes**, please indicate which ears:  Left  Right  Both

Do you feel the words are :  Not loud enough  Not clear  Both

Did your hearing loss occur:  Suddenly  Gradually

Does your hearing loss fluctuate?  Yes  No

4. Have you ever seen an Ear Nose and Throat Doctor for your ears/hearing?  Yes  No

**If yes**, please explain when, why and what did the Doctor recommend? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

5. Do you ever experience dizziness or light headedness?  Yes  No

**If yes**, please describe your symptoms and when they occur. \_\_\_\_\_

\_\_\_\_\_

6. Do you experience numbness, weakness or tingling in your face?  Yes  No

**If yes**, please describe when this occurs. \_\_\_\_\_

\_\_\_\_\_

7. Do you currently have any fullness or stuffiness in your ears?  Yes  No

8. Do you ever notice any ringing, buzzing or other noises in your ears or head?  Yes  No

**If yes**, which ears?  Left  Right  Both

Is this noise bothersome?  Yes  No

Is it constant or intermittent? \_\_\_\_\_

When did you first notice this problem? \_\_\_\_\_

**Turn over page**

9. Have you ever been exposed to loud noise?  Yes  No

10. Have you ever worked in noise?  Yes  No

11. Do you wear hearing protection?  Yes  No

**If yes**  Sometimes  All the time  Never

12. Have you ever had any medical/surgical treatment for your ears?  Yes  No

**If yes**, please describe.

13. Have you ever had chemotherapy or radiation?  Yes  No

14. Does anyone in your immediate family have hearing loss?  Yes  No

15. Have you ever worn a hearing aid?  Yes  No

**If yes**,  Left ear  Right ear  Both ears

How old is your current hearing aid? \_\_\_\_\_ years old

Do you wear your hearing aid regularly?  Yes  No

Are you happy with your hearing aid?  Yes  No

**If no**, list any concerns you have with your hearing aids: \_\_\_\_\_

\_\_\_\_\_

16. Do you have difficulty hearing in any of the following situations:

Watching TV  Using the telephone  Meetings  Restaurants

At the movies  worship service  Background noise  In a group setting

17. Has your hearing loss kept you from attending social gatherings?  Yes  No

18. Have you ever had any of the following?

Meningitis  Scarlet Fever  Seizures  Vision Problems  Arthritis

Measles  Tuberculosis  Head Injury  Allergies  CMV

Mumps  Diabetes  High Fevers  Pacemaker  HIV/AIDS

Communicable Disease  High Blood Pressure  Depression/Anxiety

19. Please list or attach a list of of your medications: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Tinnitus Reaction Questionnaire (TRQ)

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer all questions by circling the number that best reflects how your tinnitus has affected you over the past week.

Name: \_\_\_\_\_

Date: \_\_\_\_\_

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel helpless.	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
18. My tinnitus has interfered with my work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
<b>Total</b>					