CENTRE D'ACOUPHÈNE
ET D'HYPO-HYPERACOUSIE
TINNITUS, HYPO-HYPERACUSIS CENTRE

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Name: Date of birth:
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Tinnitus, Hypo-Hyperacusis Questionnaire

I thank you for taking the time to fill out this questionnaire. Your answers and comments will provide me with a greater understanding of your tinnitus / hypoacusis / hyperacusis and help me to develop a more effective and holistic approach in the management of your symptom(s). This questionnaire is an adaptation of the Tinnitus Management Clinic of the Ottawa Hospital's, General Campus, questionnaire.

PLEASE NOTE: This questionnaire can be completed on line, sensitive cases gray, and returned by email. You can also print out the questionnaire (ideally on both sides) complete it and either post it, fax it or bring it with you the day of your appointment. To complete this questionnaire on line, follow these instructions.

- To write an answer, place the cursor in the gray zone and write your answer.
- To select a box, place the cursor in the appropriate one and click with the mouse.

PART I: SYMPTOMS INVESTIGATION

1. For how long have you had…?

Hypoacusis: hearing loss ***(If never, write 0 and ignore this column of part I)***	**Hyperacusis:** noise sensitivity ***(If never, write 0 and ignore this column of part I)***	**Tinnitus:** sound/noise heard in one or both ear(s) or in the head ***(If never, write 0 and ignore this column of part I)***

For most of the following questions, please answer by darkening or selecting the corresponding choices.

2. How would you define your symptom?

☐ I occasionally, ask people repeat what they say ☐ I can't hear whispering very well ☐ I increase the TV's volume ☐ I encounter difficulties communicating with others in restaurants or during meetings. ☐ I don't understand sermons at church very well ☐ I argue with members of my family ☐ I avoid being in groups situations ☐ Other:	☐ I am sensitive to the sound of a fan ☐ I am sensitive to noise when I am in a car ☐ I am sensitive to household noise ☐ I am sensitive to noise at work ☐ I am sensitive to loud music ☐ I am sensitive to noises in restaurants ☐ Other:	☐ Clink – crunch ☐ Ocean – static ☐ Engine noise ☐ Buzz – murmur ☐ Pounding – hammering – pulse ☐ Bell – ring – tone ☐ Running water ☐ Cicada – cricket – locust ☐ Whistling – steam whistle ☐ Sizzling (frying) ☐ High tension electric cables ☐ Electric chocks in the head ☐ Music ☐Voices ☐ Other:

3. How did your symptom arise?

☐ Gradually in the right ear ☐ Gradually in the left ear ☐ Suddenly in the right ear ☐ Suddenly in the left ear ☐ Both ears unequally, worse in:	☐ Gradually in the right ear ☐ Gradually in the left ear ☐ Suddenly in the right ear ☐ Suddenly in the left ear ☐ Both ears unequally, worse in:	☐ Gradually in the right ear ☐ Gradually in the left ear ☐ Suddenly in the right ear ☐ Suddenly in the left ear ☐ Both ears unequally, worse in: ☐ Inside your head ☐ Outside your head

4. Evaluate your symptom with the following scale, 0=absent, 1= minor, 2= moderate, 3= severe.

5. How would you describe the severity of each of your symptoms?

☐ A little embarrassing - frustrating ☐ Occasionally embarrassing - frustrating ☐ Often embarrassing - frustrating ☐ Always embarrassing - frustrating ☐ I isolate myself from others • *Do you wear hearing aids?* ☐ No ☐ Yes, right ear ☐ Yes, left ear • *If yes, what is your level of discomfort?*	☐ Slightly sensitive ☐ Occasionally sensitive ☐ Often sensitive ☐ Always sensitive ☐ I can't go out without protective device	☐ Present – not disturbing ☐ Disturbing but I can ignore it ☐ Hard to ignore ☐ Always disturbing ☐ Almost always intrusive

6. Since the beginning, how would you define the progression of each of your symptoms?

☐ Absent ☐ Better ☐ Same ☐ It fluctuates ☐ Worst	☐ Absent ☐ Better ☐ Same ☐ It fluctuates ☐ Worst	☐ Absent ☐ Better ☐ Same ☐ It fluctuates ☐ Worst • *For the pitch:* ☐ Lower ☐ Same ☐ It fluctuates ☐ Higher • *For the intensity:* ☐ Less ☐ Same ☐ It fluctuates ☐ Worst

7. If it fluctuates indicate for each of the following items, those that make your symptoms appear better (+) or worse (-).

When I'm rested (in the morning)	When I'm rested (in the morning)	When I'm rested (in the morning)
When I'm tired (at night)	When I'm tired (at night)	When I'm tired (at night)
When I'm sleeping/resting/falling asleep	When I'm sleeping/resting/falling asleep	When I'm sleeping/resting/falling asleep
When I'm angry	When I'm angry	When I'm angry
When I'm happy, calm	When I'm happy, calm	When I'm happy, calm
When I'm tense or anxious	When I'm tense or anxious	When I'm tense or anxious
When I wear hearing aids	When I wear hearing aids	When I wear hearing aids
When I wear ear protectors	When I wear ear protectors	When I wear ear protectors
When I hear static noise on the radio or when I wear a masking device	When I hear static noise on the radio or when I wear a masking device	When I hear static noise on the radio or when I wear a masking device
When I'm in quiet places	When I'm in quiet places	When I'm in quiet places
When I'm exposed to low noise	When I'm exposed to low noise	When I'm exposed to low noise
When I'm exposed to loud noise	When I'm exposed to loud noise	When I'm exposed to loud noise
When I listen to the radio, the TV or to music	When I listen to the radio, the TV or to music	When I listen to the radio, the TV or to music
When doing physical activities, moving my head	When doing physical activities, moving my head	When doing physical activities, moving my head
A change in altitude	A change in altitude	A change in altitude
When I take medication	When I take medication	When I take medication
When I drink alcohol	When I drink alcohol	When I drink alcohol
	When I drink coffee, tea, cola soft drinks or chocolate beverage	When I drink coffee, tea, cola soft drinks, energy dink or chocolate beverage
	During my menstruation (for women)	During my menstruation (for women)
	When I'm active	When I'm active

8. Can you relate any specific event to the onset of your hypoacusis / hyperacusis / tinnitus?

☐ An ear/sinus infection	☐ An ear/sinus infection	☐ An ear/sinus infection
☐ A long exposure to noise	☐ A long exposure to noise	☐ A long exposure to noise
☐ Head injury	☐ Head injury	☐ Head injury
☐ Exposure to a short loud noise	☐ Exposure to a short loud noise	☐ Exposure to a short loud noise
☐ Whiplash - cervical trauma	☐ Whiplash - cervical trauma	☐ Whiplash - cervical trauma
☐ A disease	☐ A disease	☐ A disease
☐ A surgery	☐ A surgery	☐ A surgery
☐ Medication	☐ Medication	☐ Medication
☐ No special event	☐ No special event	☐ No special event
☐ Other:	☐ Other:	☐ Other:

9. Which one of the following medical health professionals have you consulted regarding your hypoacusis / hyperacusis / tinnitus?

☐ None	☐ None	☐ None
☐ General practitioner	☐ General practitioner	☐ General practitioner
☐ ENT specialist	☐ ENT specialist	☐ ENT specialist
☐ Audiologist	☐ Audiologist	☐ Audiologist
☐ Hearing aid dealer	☐ Hearing aid dealer	☐ Hearing aid dealer
☐ Neurologist	☐ Neurologist	☐ Neurologist
☐ Dentist/ TMJ specialist	☐ Dentist/ TMJ specialist	☐ Dentist/ TMJ specialist
☐ Psychologist/psychiatrist	☐ Psychologist/psychiatrist	☐ Psychologist/psychiatrist
☐ Chiropractor	☐ Chiropractor	☐ Chiropractor
☐ Physiotherapist	☐ Physiotherapist	☐ Physiotherapist
☐ Osteopath	☐ Osteopath	☐ Osteopath
☐ Pharmacist	☐ Other:	☐ Massage therapist
☐ Naturopath		☐ Naturopath
☐ Other:		☐ Dietician
		☐ Pharmacist
		☐ Other:

10. For each of the following treatments that you have tried, indicate their effectiveness on each of your symptoms by (-1) if it got worst, (0) if you have noticed no improvement, (1) if it got slightly better and (2) if it eliminates your symptom.

Hearing aids	Hearing aids	Hearing aids
Deafening device	Deafening device	Deafening device
Ear protectors	Ear protectors	Ear protectors
Surgery	Surgery	Surgery
Medication	Medication	Medication
Vitamins/diet	Vitamins/diet	Vitamins/diet
Acupuncture	Acupuncture	Acupuncture
Chiropractic	Chiropractic	Chiropractic
Physiotherapy	Physiotherapy	Physiotherapy
Relaxation	Relaxation	Relaxation
Other:	Biofeedback	Biofeedback
	Hypnosis	Hypnosis
	Psychotherapy	Psychotherapy
	Electric stimulation	Electric stimulation
	Other:	Other:

11. For each of your symptoms, indicate its interference using the following scale: 0=never, 1=sometimes, 2=often, 3=always

With my personal life (happiness)	With my personal life (happiness)	With my personal life (happiness)
With my family life	With my family life	With my family life
Whit my social life	Whit my social life	Whit my social life
With my work	With my work	With my work
With my mental process (reading, concentration)	With my mental process (reading, concentration)	With my mental process (reading, concentration)
With my sleep	With my sleep	With my sleep

12. Indicate your average hours of sleep per night:

13. If your quality of sleep is affected, describe the effect of each symptom?

☐ It takes longer to fall asleep	☐ It takes longer to fall asleep	☐ It takes longer to fall asleep
☐ It wakes me up when I'm asleep	☐ It wakes me up when I'm asleep	☐ It wakes me up when I'm asleep
☐ It's not linked to my hypoacusis	☐ It's not linked to my hyperacusis	☐ It's not linked to my tinnitus

PART II: HEARING AND GENERAL HEALTH HISTORY:

Please consider all of the choices by darkening or selecting the appropriate answers and give the requested information.

14. Are you susceptible to ear-related problems? ☐ No ☐ If yes, indicate which ones:

☐ Ear infection	☐ Drainage	☐ Surgery
☐ Perforation	☐ Pain	

15 Has anyone in your family ever had a hearing problem before age 50? ☐ No ☐ Yes, relation:

16.a) Have you ever been exposed to loud noises? ☐ No ☐ If yes

Explain:	How many years:	Ear protection?

b) Do you actually work in a noisy environment? ☐ No ☐ If yes

Explain:	How many years:	Ear protection?

c) Do you practice noisy hobbies (target range shooting, hunting, carpentry...)? ☐ No ☐ If yes

Which one:	How many years:	Ear protection?

d) Have you ever played music regularly? ☐ No ☐ If yes

Which one:	How many years:	Ear protection (ER)?

17. Do you suffer from TMJ (temporomandibular joint disorder)?

☐ No ☐ If yes How many years:

Do you have a painful cracking of the jaw?	Do you grind or clenching your teeth?	Do you have prosthesis?
☐ No ☐ Yes	☐ No ☐ Yes	☐ No ☐ Yes

18. Do you suffer from:

☐ Arthritis	☐ Thyroid gland	☐ Dizziness- vertigo
☐ Headache - migraine	☐ Hypertension	☐ Clinical depression
☐ Allergies	☐ Neck problems - cervical	☐ Anxiety
☐ Sinusitis	☐ Anemia	☐ Obsessive - compulsive behavior
☐ High cholesterol level	☐ Diabetes	☐ Bipolar/Manic-depressive behavior
☐ Other:	☐ Constipation	

19. Do you take any medication at the moment? ☐ *No* ☐ If *yes, which one(s) and what are the directions for use (aspirin included).*

20. Do you smoke:

☐ Tobacco	☐ Marijuana	☐ Other drugs, which ones:
How many years:	How many years:	How many years:
How many per day:	How many per day:	How many per day:

21. Do you drink any of these (please indicate the number of "small" cups or glasses per day):

☐ Coffee with caffeine ☐ Tea with caffeine ☐ Soft drinks with caffeine
☐ Hot chocolate ☐ Alcohol, which one ☐ Tonic water (ex. gin tonic)
☐ Energy dink

22. Do you use any of these on a daily basis?

☐ Sugar ☐ Salt ☐ Spices
☐ MSG ☐ Foods with additives

23. ***Do you exercise regularly?*** ☐ *No* ☐ *If yes, how many days a week?*

24. Presently, are you going through many stressful situations? ☐ *No* ☐ *If yes, why?*

25. In general, are you satisfied with your lifestyle?

☐ Very unsatisfied ☐ Satisfied ☐ Very satisfied

If you are unsatisfied, it is primarily due to your…

☐ Hypoacusis ☐ Hyperacusis ☐ Tinnitus

26. Please indicate your fears regarding your hypoacusis / hyperacusis / tinnitus:

27. I want help with my hypoacusis / hyperacusis / tinnitus because:

28. Other comments:

Signature: Date:

FOR INTERNAL USE ONLY
TINNITUS EVALUATION SYSTEM (From A.Kodama, M.Kitahara, K.Komada, 1994):

L(____) + A (____) + I (____) = ____ **L(____) + A (____) + I (____) = ____** **L(____) + A (____) + I (____) = ____**