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...?

<table>
<thead>
<tr>
<th>Hypoacusis: hearing loss</th>
<th>Hyperacusis: noise sensitivity</th>
<th>Tinnitus: sound/noise heard in one or both ear(s) or in the head</th>
</tr>
</thead>
<tbody>
<tr>
<td>(If never, write 0 and ignore this column of part I)</td>
<td>(If never, write 0 and ignore this column of part I)</td>
<td>(If never, write 0 and ignore this column of part I)</td>
</tr>
</tbody>
</table>

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

2. How would you define your symptom?

<table>
<thead>
<tr>
<th>Hypoacusis:</th>
<th>Hyperacusis:</th>
<th>Tinnitus:</th>
</tr>
</thead>
<tbody>
<tr>
<td>I occasionally, ask people repeat what they say</td>
<td>I am sensitive to the sound of a fan</td>
<td>Clink – crunch</td>
</tr>
<tr>
<td>I can’t hear whispering very well</td>
<td>I am sensitive to noise when I am in a car</td>
<td>Ocean – static</td>
</tr>
<tr>
<td>I increase the TV’s volume</td>
<td>I am sensitive to household noise</td>
<td>Engine noise</td>
</tr>
<tr>
<td>I encounter difficulties communicating with others in restaurants or during meetings.</td>
<td>I am sensitive to noise at work</td>
<td>Buzz – murmur</td>
</tr>
<tr>
<td>I don’t understand sermons at church very well</td>
<td>I am sensitive to loud music</td>
<td>Pounding – hammering – pulse</td>
</tr>
<tr>
<td>I argue with members of my family</td>
<td>I am sensitive to noises in restaurants</td>
<td>Bell – ring – tone</td>
</tr>
<tr>
<td>I avoid being in groups situations</td>
<td>Other:</td>
<td>Running water</td>
</tr>
</tbody>
</table>

| Cicada – cricket – locust | Electric chocks in the head | High tension electric cables |
| Whistling – steam whistle | Music | Sizzling (frying) |
| Sizzling (frying) | Voices | Electric chocks in the head |
| Electric chocks in the head | Music | High tension electric cables |
| Music | Voices | Electric chocks in the head |
| Voices | Other: | Electric chocks in the head |
| Other: | | Electric chocks in the head |
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:

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

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

<table>
<thead>
<tr>
<th>When I’m rested (in the morning)</th>
<th>When I’m tired (at night)</th>
<th>When I’m sleeping/resting/falling asleep</th>
<th>When I’m angry</th>
</tr>
</thead>
<tbody>
<tr>
<td>When I’m happy, calm</td>
<td>When I’m tense or anxious</td>
<td>When I wear hearing aids</td>
<td>When I wear ear protectors</td>
</tr>
<tr>
<td>When I hear static noise on the radio or when I wear a masking device</td>
<td>When I’m in quiet places</td>
<td>When I’m exposed to low noise</td>
<td>When I’m exposed to loud noise</td>
</tr>
<tr>
<td>When I listen to the radio, the TV or to music</td>
<td>When I’m in quiet places</td>
<td>When I’m exposed to low noise</td>
<td>When I’m exposed to loud noise</td>
</tr>
<tr>
<td>When I’m tense or anxious</td>
<td>When I wear ear protectors</td>
<td>When I listen to the radio, the TV or to music</td>
<td>When I’m active</td>
</tr>
<tr>
<td>When I listen to the radio, the TV or to music</td>
<td>When I’m in quiet places</td>
<td>When I’m exposed to low noise</td>
<td>When I’m exposed to loud noise</td>
</tr>
<tr>
<td>When I’m active</td>
<td>When I listen to the radio, the TV or to music</td>
<td>When I’m in quiet places</td>
<td>When I’m exposed to low noise</td>
</tr>
</tbody>
</table>

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

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

- An ear/sinus infection
- A long exposure to noise
- Head injury
- Exposure to a short loud noise
- Whiplash - cervical trauma
- A disease
- A surgery
- Medication
- No special event
- Other:
9. Which one of the following medical health professionals have you consulted regarding your hypoacusis / hyperacusis / tinnitus?

<table>
<thead>
<tr>
<th>Professional</th>
<th>None</th>
<th>General practitioner</th>
<th>ENT specialist</th>
<th>Audiologist</th>
<th>Hearing aid dealer</th>
<th>Neurologist</th>
<th>Dentist/ TMJ specialist</th>
<th>Psychologist/psychiatrist</th>
<th>Chiropractor</th>
<th>Physiotherapist</th>
<th>Osteopath</th>
<th>Other:</th>
</tr>
</thead>
</table>

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.

<table>
<thead>
<tr>
<th>Treatment</th>
<th>Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hearing aids</td>
<td>Hearing aids</td>
</tr>
<tr>
<td>Deafening device</td>
<td>Deafening device</td>
</tr>
<tr>
<td>Ear protectors</td>
<td>Ear protectors</td>
</tr>
<tr>
<td>Surgery</td>
<td>Surgery</td>
</tr>
<tr>
<td>Medication</td>
<td>Medication</td>
</tr>
<tr>
<td>Vitamins/diet</td>
<td>Vitamins/diet</td>
</tr>
<tr>
<td>Acupuncture</td>
<td>Acupuncture</td>
</tr>
<tr>
<td>Chiropractic</td>
<td>Chiropractic</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>Physiotherapy</td>
</tr>
<tr>
<td>Relaxation</td>
<td>Relaxation</td>
</tr>
<tr>
<td>Biofeedback</td>
<td>Biofeedback</td>
</tr>
<tr>
<td>Hypnosis</td>
<td>Hypnosis</td>
</tr>
<tr>
<td>Psychotherapy</td>
<td>Psychotherapy</td>
</tr>
<tr>
<td>Electric stimulation</td>
<td>Electric stimulation</td>
</tr>
<tr>
<td>Other:</td>
<td>Other:</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Interference</th>
</tr>
</thead>
<tbody>
<tr>
<td>With my personal life (happiness)</td>
<td>With my personal life (happiness)</td>
</tr>
<tr>
<td>With my family life</td>
<td>With my family life</td>
</tr>
<tr>
<td>With my social life</td>
<td>With my social life</td>
</tr>
<tr>
<td>With my work</td>
<td>With my work</td>
</tr>
<tr>
<td>With my mental process (reading, concentration)</td>
<td>With my mental process (reading, concentration)</td>
</tr>
<tr>
<td>With my sleep</td>
<td>With my sleep</td>
</tr>
</tbody>
</table>

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 wakes me up when I’m asleep
- It’s not linked to my hypoacusis
- It takes longer to fall asleep
- It wakes me up when I’m asleep
- It’s not linked to my hyperacusis
- It takes longer to fall asleep
- It wakes me up when I’m asleep
- 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
- Perforation
- Drainage
- Pain
- Surgery

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 prosthesis? □ No □ Yes
  - Do you have a painful cracking of the jaw?
    - No □ Yes
  - Do you grind or clenching your teeth? □ 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
  - Other drugs, which ones:

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:
21. Do you drink any of these (please indicate the number of "small" cups or glasses per day):
   - Coffee with caffeine
   - Tea with caffeine
   - Hot chocolate
   - Alcohol, which one
   - Soft drinks with caffeine
   - Tonic water (ex. gin tonic)
   - Energy drink

22. Do you use any of these on a daily basis?
   - Sugar
   - Salt
   - MSG
   - Spices
   - 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
TINTNITUS EVALUATION SYSTEM (From A.Kodama, M.Kitahara, K.Komada, 1994):

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