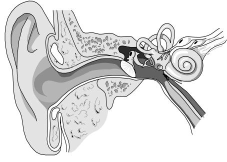
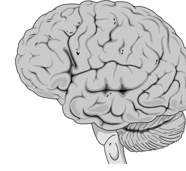
TINNITUS QUESTIONNAIRE



for patients with
NOISE IN THEIR EARS



Chicago Dizziness and Hearing
645 N. Michigan, Suite 410
Chicago, Illinois, 60611

NAME	
AGE	
TODAY'S DATE	
SOCIAL SEC #	

SEND REPORT TO:

HOME PHONE #	
WORK PHONE #	
PHARMACY #	
PATIENT'S FAX	
Email	

YOUR ADDRESS:

Sex:__M__F Birthdate:___/___/___   ___Single___Married___Widowed___Separated___Divorced

Patient Employed by:____

Business Address:Street__________________________City________________State____Zip_________

Primary Insurance:______________________________   Card Holder Name:___________________

Secondary Insurance:____________________________   Card Holder Name:___________________

Sign below to indicate that:

1. We offered you a copy of our Privacy Policy statement for your review
2. We have your permission to ask your doctor for records related to the reason for this appointment
3. I hereby authorize the release of any information needed by my carrier to process the claim. I understand that I am financially responsible for all charges; these may include, but are not limited to, deductibles, co-pays, and "non-covered services".
4. We have your permission to use video material of your eye (where you cannot be recognized) in research or educational works.

Signature ______________________

Please answer the following questions and bring the answers to your appointment. There is room at the end of each section for additional comments. Please give necessary details for "yes" answers. We realize that this form is long, but when it is filled out carefully it allows us to devote more time to examining you.

<u>**Tinnitus QUESTIONNAIRE**</u>

1. Present Illness

My tinnitus (noises in ear) started on: ____________________

My tinnitus is in	both ears	Right	left
The pitch is	low	medium	high
It pulsates (is in time with pulse)		yes	no

It sounds like:

Ringing	Thumping
Hissing	Buzzing
Locust	Crickets
Musical	Crashing
Voices	

Is the tinnitus <u>constantly</u> present, or does it appear in <u>attacks</u>?

If in attacks,

how often?

how long?

Do you have any warning that an attack is about to start?

My tinnitus

Doesn't bother me

Makes me lose sleep

Makes me depressed

Tinnitus QUESTIONNAIRE

2. Are your tinnitus problem affected or brought on by

TRIGGER	**YES**	**NO**
Moving the jaw		
Standing up		
Turning the head on neck		
Loud noises		
Foods, eating or not eating		
Salt		
monosodium glutamate (MSG)		
Time of day, particular seasons		
Stress		

Are there other triggers?:

Tinnitus QUESTIONNAIRE

3. **Ear Problems:** Have you ever had (circle side or both)

Sensitivity to Noise	No	Right	Left
Fullness or pressure in ear	No	Right	Left
Pain in ear	No	Right	Left
Unable to hear clearly	No	right	Left
Do you use a hearing aid?	No	Right	Left

4. **Life Style**

How much alcohol do you *drink per week*?

How much *salt* do you use on your food?

What sort of *work* do you do (or used to do)?

Does your work depend on good hearing ?

How often do you *fly on airplanes*?

Have you ever been scuba diving ?

Are you presently in litigation or planning litigation about symptoms related to this visit?

Are you disabled due to your condition?

Do you drive ?

(Women only) are you
- pregnant?
- Perimenopausal?
- Postmenopausal ?

5. **Injuries** (circle)

to ears

to head (for example, concussion -- please list ALL)

If in motor vehicle accident, did airbags deploy ?

6. **Exposure** (circle)

Loud noise (i.e. musicians, machinists, building trades)

7. Past or present health has been affected by (circle)

Constitutional

Weight Loss (15 LB or more)

Trouble sleeping?
- Due to tinnitus ?
- Due to dizziness?
- Due to depression?
- Due to snoring ?

CARDIOVASCULAR

Anemia

Fainting

Heart problems

High cholesterol

High blood pressure

Low blood pressure

Diabetes

Palpitations (abnormal or fast beating) of the heart

CANCER

What type and when?

ENDOCRINE

Low sugar (hypoglycemia)

Thyroid disorder

PSYCHOLOGICAL

Treatment by a psychiatrist or counselor

Depression

Unusual amounts of stress

PAIN

Arthritis

Pain in back of jaw (TMJ)

Migraine, Sinus or tension headaches

Low Back Pain

Neck Pain

IMMUNOLOGIC

Allergy (to what?)

Lupus/other autoimmune disease

BREATHING PROBLEMS

Asthma

Pneumonia

Sinusitis

Deviated Septum

STOMACH PROBLEMS

Ulcer

Reflux/Hiatal Hernia

Irritable bowel

EYE PROBLEMS (other than glasses)

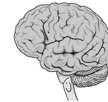
Crossed eyes, lazy eye

Poor vision in one eye

Cataract

Macular Degeneration

Double vision?



NEUROLOGICAL PROBLEMS

B12 Deficiency

Carpal Tunnel

Memory loss

Meningitis

Multiple Sclerosis

Pins and needles, numbness (where)

Muscle, paralysis or weakness (where)

Seizures

Speech disturbance

Tremor or incoordination

RENAL/GENITOURINARY

Bladder Problem

Sexual function problem

Kidney problem

8. SURGERY

☐ Breast cancer	☐ Cataract	☐ Carotid	☐ C-Section
☐ Ear	☐ Epidural Injection	☐ Hysterectomy	☐ Prostate
☐ Sinus	☐ Stomach	☐ Tonsil	

Other _____

FAMILY HISTORY

9. Are there any **family members** with (circle, list):

Dizziness, balance or hearing symptoms:

Balance problems

Hearing loss starting at age < 40

Otosclerosis

Vertigo or dizziness

Meniere's syndrome

Symptoms like your own

Convulsions or seizures

Migraine headaches

Other diseases that run in the family? (please list)

What is your ethnicity ? (some genetic populations are more prone to develop dizziness)

MEDICATIONS

10a. What are your current medications, include hormones, allergy shots, birth control pills, vitamins, etc. (Name and amount/day)?

1.
2.
3.
4.
5.
6.
7.
8.
9.
10.

10b. What other medications have you taken in the last 5 years, for this problem or others?

1.
2.
3.
4.
5.

10c. Have you undergone physical therapy for your condition? ☐
Chiropractic treatment? ☐
Acupuncture? ☐
Alternative medicines (such as Ginkgo, St. Johns Wort?) ☐

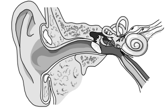
10d. **Have you ever taken any of the following drugs? Mark the ones that you have taken.**

☐ Aspirin, in large dosage
☐ Cisplatin (for cancer)
☐ Furosemide (Lasix)
☐ Gentamicin (antibiotic)
Intravenous antibiotics --
- ☐ Kanamycin (antibiotic)
- ☐ Streptomycin (obsolete antibiotic)
- ☐ Tobramycin (antibiotic)
- ☐ Vancomycin (antibiotic)

☐ Malaria prevention drugs (chloroquine, Larium)
☐ Tamoxifen (to prevent breast cancer)

PREVIOUS STUDIES

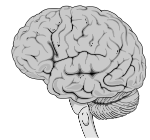
11. Have you had any of these tests? (date if done and note result if known)



EAR TESTS:

- ☐ ABR or BAER test (evoked potential test)
- ☐ ECOG (evoked potentials for Meniere's syndrome)
- ☐ ENG Caloric test (hot and cold, water or air in ear),
- ☐ Hearing test (audiogram)
- ☐ OAE (Otoacoustic emissions)
- ☐ Posturography test (balance test)
- ☐ Rotatory Chair test (spinning test)
- ☐ VEMP (vestibular evoked myogenic potential)

NEUROLOGICAL TESTS



- ☐ Carotid Doppler or cerebral angiogram
- ☐ EEG (Brain wave test for seizures)
- ☐ Lumbar puncture (spinal fluid examination, spinal tap)

GENERAL MEDICAL TESTS

- ☐ Recent general medical checkup?
- ☐ Recent general blood tests
  - blood count,
  - Cholesterol
  - Glucose,
  - Thyroid tests
- ☐ Heart testing (EKG, Echo, Stress test, Holter Monitor)
- ☐ Tilt table test

X-RAYS

- ☐ Chest X-ray
- ☐ Ear: CT scan of inner ear (Temporal bone CT)
- ☐ Head: MRI, MRA and/or CT scan
- ☐ Neck: X-rays, CT or MRI scan
- ☐ PET scan
- ☐ Sinus: X-rays or CT scan

Other Important Tests: