BALANCE and EAR CENTER inc.

Virginia Hearing Center

Name _____ Date _____

Address _____
Street City State Zip

Home Phone _____ Other Phone _____

Sex ☐ M ☐ F Birth Date _____ Email Address _____

Primary Care Physician _____ Referred by _____

Occupation/Former Occupation _____

PLEASE ANSWER THE FOLLOWING GROUPS OF QUESTIONS

Have you ever?	
Had any noisy jobs?	☐ Yes ☐ No
Had any noisy hobbies or home activities?	☐ Yes ☐ No
Used solvents, thinners or alcohol based cleaners?	☐ Yes ☐ No
Taken any of the following medications: *Quinine, Quinidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin*	☐ Yes ☐ No
Had any ear surgeries?	☐ Yes ☐ No
If so, describe:	
Do you?	
Have loose dentures, jaw pain or a grinding or clicking sensation in the jaw?	☐ Yes ☐ No
Have any pain in your ears?	☐ Yes ☐ No
Have any feelings of ear pressure or blockage?	☐ Yes ☐ No
Have any feelings of dizziness?	☐ Yes ☐ No
Regularly take aspirin or disprin?	☐ Yes ☐ No
Take any medications?	☐ Yes ☐ No
If so, please list:	
General Hearing Problems	
Do you have any difficulty hearing when there is background noise?	☐ Yes ☐ No
Do you have difficulty understanding one-to-one conversations?	☐ Yes ☐ No
Do you have difficulty hearing the TV?	☐ Yes ☐ No
Do you have difficulty hearing on the telephone?	☐ Yes ☐ No
Do you find external sounds unpleasant or uncomfortable?	☐ Yes ☐ No
If so, please list:	
Do you wear ear protection/earplugs?	☐ Yes ☐ No
If so, how often and under what circumstances?	
Impact of Your Tinnitus	
Over the past week, what percentage of the time you were awake were you aware of your tinnitus? *(e.g. 100% aware - all the time, 25% aware - 1/4 of the time)*	%
What percentage of the time was it disturbing?	%

Rank the percentage (%) of time you are aware of the your tinnitus in the following situations (1-100%)


SLEEP _____%


QUIET ROOM _____%


SMALL CONVERSATION _____%


AT WORK _____%


OUTDOORS _____%


IN CROWDS _____%

In which ear does your tinnitus occur? ☐ Left ☐ Right ☐ Both ☐ Worse Right ☐ Worse Left ☐ Equal Effect

Is your tinnitus constant or intermittent? _____

Does your tinnitus fluctuate in intensity or loudness? _____

What makes your tinnitus worse? _____

What makes your tinnitus better? _____

Does your tinnitus prevent you from getting to sleep at night? ☐ Yes ☐ No

Do you find that exposure to moderately loud sounds makes your tinnitus worse? ☐ Yes ☐ No

Does your tinnitus affect your sleep? ☐ Yes ☐ No

How has tinnitus affected your work life? _____

How has tinnitus affected your home life? _____

How has tinnitus affected your social activities? _____

TINNITUS HISTORY

When did you first become aware of your tinnitus and what do you consider to have first started your tinnitus?

When did your tinnitus first become disturbing? _____

Who have you consulted about your tinnitus? _____

What have you been told about your tinnitus? _____

What treatments have you tried for your tinnitus? ☐ None ☐ TRT ☐ Hearing Device ☐ Counseling ☐ Masker ☐ Music Therapy ☐ Other, please comment _____

How successful did you find these treatments? _____

Please rank the auditory problems you experience: Not very troublesome (1) to very troublesome (10)

_____ Hearing _____ Tinnitus _____ Sensitivity to loud sounds