Tinnitus and Hyperacusis Program

We thank you for your inquiry into the Tinnitus and Hyperacusis Program.

**Important**
If you are experiencing a sudden loss of hearing, drainage from the ears or facial numbness or paralysis, contact the Ear, Nose and Throat Clinic for an appointment *immediately* at 414-805-5580.

**Is Your Primary Concern Hearing Loss?**
If your primary concern is hearing loss, and your tinnitus is not distressing, you do not need to complete the tinnitus packet. We recommend you begin with a comprehensive hearing evaluation. Call 414-805-5587 to schedule a hearing evaluation.

Our Tinnitus and Hyperacusis Program begin in 2008 to help people who are seeking help for distressing noises in the ears or head and sound sensitivity issues. We recognize that tinnitus and sound sensitivity are troubling and life-changing conditions and wish to get you on the road to recovery in the most efficient manner possible.

So we may best serve your individual needs, please complete the enclosed history forms and questionnaires. You can return them via mail, fax or MyChart. Once the forms are received and reviewed, we will call you to set up an appointment. At the time we call, we will tell you which tests and appointments are appropriate for you and which audiologist will best meet your specific needs.

Please send any outside records specifically related to your history of tinnitus or sound sensitivity, such as hearing tests and any pertinent medical office notes along with the completed paperwork.

Also included is a billing agreement that we ask you to read, sign and return to us along with the questionnaires. All forms need to be returned before an appointment can be scheduled. You can expect a call within a week of the date the completed questionnaires are received.

We look forward to serving you!

The Tinnitus and Hyperacusis Program Team
Department of Otolaryngology
Attn: Audiology
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
Phone: 414-805-8569
Fax: 414-269-8157
E-mail: audiology@froedtert.com
Tinnitus Management Appointment Agreement

This packet is for the Tinnitus and Hyperacusis Program management/consultation appointment to guide you in how to manage the distress of your symptoms and reduce the impact symptoms have on your life. Our team may recommend this appointment. This is determined once we have received and reviewed your completed paperwork, including this signed patient agreement.

After reading the attached materials, please initial each of the items below and sign at the bottom of the page.

**I understand that:**

_____ The purpose of the appointment is to educate me in establishing a tinnitus or hyperacusis management program. The appointment is not intended to result in a cure for my tinnitus.

_____ There is no specific insurance coding for tinnitus counseling. My insurance company will not be billed, and the Audiology Clinic will not accept insurance payment for this appointment.

_____ I will pay for the appointment on the date of service. The appointment fee is $180.

_____ We require a 24-hour cancellation notice due to the length of these appointments. If a 24-hour notice is not provided, we will consider it a no-show appointment and, at our discretion, we may not reschedule the appointment.

_____ We will bill any test procedure for tinnitus, including hearing tests, to your insurance. It is your responsibility to determine with your insurance company if the hearing testing is covered, including deductibles and co-pay.

**I agree to the terms as noted above.**

___________________________  ___________________________                 ___________________
Patient Name (printed)   Patient/Guardian Signature            Date

**Important:** Insurance does not cover the cost of tinnitus counseling and management. The cost for this service is $180. Follow-up counseling is billed at $120 per visit. You will be responsible for the cost of services not covered by your health insurance. These fees do not cover the cost of hearing aids, earplugs and/or sound generating devices.

**NOTE:** The purpose of our program is to help guide patients in managing the distress of their symptoms. If you are involved in any legal action regarding your symptoms, our doctors and clinicians are not available as expert witnesses or to provide any legal guidance or opinions.
Tinnitus History Questionnaire

Name: ____________________________ Date of birth: _________ Date completed: __________

Phone: ___________________ Email: _________________________________________________

Who referred you?

Physician: ________________________________________________________________

Self (how did you hear about our program?): __________________________________________

Background questions

Home/family situation (list who lives with you): _________________________________________
________________________________________________________________________________
________________________________________________________________________________

Work situation: Current or previous work history? _______________________________________
________________________________________________________________________________
________________________________________________________________________________

Retired? (circle) Yes  No; if yes, when: ________________________________________________

Have you had any extended periods of sick leave within the last six months? (circle) Yes  No

If yes, part time or full time? (circle one)

Nature of the Tinnitus

How does the tinnitus sound?   Ring   Buzz   Hum   Roar   Tone   Static   Music
 Other (describe): ______________________________________________________________

Usual site of the tinnitus?   Both ears   Right ear   Left ear   Central
 Right worse than left   Left worse than right

What makes your tinnitus worse?  _______________________________________________________

What makes your tinnitus better?  _______________________________________________________

Is your tinnitus constant? (circle) Yes  No

Does your tinnitus fluctuate in intensity? (circle) Yes  No

Does your tinnitus pulsate? (circle) Yes  No  If yes, does it pulse with your heartbeat? Yes  No

Can you change your tinnitus? (circle) Yes  No

If yes, how? Movement of □ Jaw  □ Neck  □ Head □ Eyes □ Other: ________________________

Which ear? (circle) Right  Left
Tinnitus History

When did you first become aware of your tinnitus? _______________________________________
__________________________________________________________________________________

When did your tinnitus become bothersome? _____________________________________________
__________________________________________________________________________________

What do you consider to have started the tinnitus? _______________________________________  
__________________________________________________________________________________

Who have you consulted about your tinnitus? ____________________________________________
__________________________________________________________________________________

What have previous professionals said your tinnitus is due to? _____________________________
__________________________________________________________________________________

What treatments have you tried for your tinnitus? (Check all that apply.)

□ None  □ Hearing aid  □ Masker/sound generator
□ TRT  □ Counseling (CBT)  □ Music or other sound
□ Other (Please explain.) __________________________

How successful did you find these treatments? __________________________________________
__________________________________________________________________________________

Do you now, or have you ever had the following: (Check all that apply.)

□ Noise exposure (past or present)?  □ Ear surgery
   (Gunfire, military, music concerts, noisy job,  □ Ear infections
   hobbies or home activities)  □ Diagnosis of ear disease
   □ Hearing loss  Do you experience now (or recently):
   □ Family member with hearing loss  □ Vertigo/dizziness/imbalance
   □ Head injuries  □ Ear pain/pressure/fullness
   □ Neck injuries/problems

If you checked “yes” to any of the above, please write details/comments in the lines below.
__________________________________________________________________________________

__________________________________________________________________________________
Other diagnoses and medical history:

- History of temporomandibular joint (TMJ) disease
- Teeth clenching/grinding
- Dental work associated with onset or increase of tinnitus
- High blood pressure
- Heart disease
- Kidney disease
- Liver disease
- Treatment with chemotherapy or radiation
- Depression/anxiety
- Contact with psychiatrist/psychologist
- Diabetes
- Other diagnosed diseases/syndromes: (e.g., Lyme disease, fibromyalgia, multiple sclerosis):

If you checked “yes” to any of the above, please write details/comments in the line below.

Hearing aid history:

Do you currently/have you ever worn hearing aids? (circle)  Yes  No

If so, what brand/type do you have?

How old are your current aids?

Do they help your hearing?

Do you notice a change in your tinnitus with your hearing aids in? (circle)  Yes  No

Effects of Tinnitus

Does your tinnitus prevent you from getting to sleep or staying asleep? (circle)  Yes  No

Have you been prescribed any of the following types of medications (sleeping pills, anxiety medications, etc.) (circle)  Yes  No

List:

Describe how tinnitus has affected your home life?

Describe how tinnitus has affected your social life?
Tinnitus History Questionnaire continued

Describe how tinnitus has affected your work life? ____________________________________________
____________________________________________________________________________________

What activities/places do you avoid because of your tinnitus? ________________________________
____________________________________________________________________________________

Describe how tinnitus has affected your enjoyment of life? _________________________________
____________________________________________________________________________________

What is your biggest concern or fear regarding your tinnitus? ______________________________
____________________________________________________________________________________

Please write in the lines below anything else you would like to add that might be relevant to understanding what caused your tinnitus or how you feel about your tinnitus.
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What are your goals for coming to our clinic?
____________________________________________________________________________________
____________________________________________________________________________________

Are there any pending legal actions regarding your tinnitus, sound sensitivity or hearing loss?
   (circle) Yes   No
Tinnitus Handicap Inventory

Instructions: The purpose of this questionnaire is to identify difficulties you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1. Because of your tinnitus, it is difficult for you to concentrate? [□] [□] [□] [□] [□]
2. Does the loudness of your tinnitus make it difficult for you to hear people? [□] [□] [□] [□] [□]
3. Does your tinnitus make you angry? [□] [□] [□] [□] [□]
4. Does your tinnitus make you feel confused? [□] [□] [□] [□] [□]
5. Because of your tinnitus, do you feel desperate? [□] [□] [□] [□] [□]
6. Do you complain a great deal about your tinnitus? [□] [□] [□] [□] [□]
7. Because of your tinnitus, do you have trouble falling asleep at night? [□] [□] [□] [□] [□]
8. Do you feel as though you cannot escape your tinnitus? [□] [□] [□] [□] [□]
9. Does your tinnitus interfere with your ability to enjoy your activities (such as going out to dinner or to the movies)? [□] [□] [□] [□] [□]
10. Because of your tinnitus, do you feel frustrated? [□] [□] [□] [□] [□]
11. Because of your tinnitus, do you feel you have a terrible disease? [□] [□] [□] [□] [□]
12. Does your tinnitus make it difficult for you to enjoy life? [□] [□] [□] [□] [□]
13. Does your tinnitus interfere with your job or household responsibilities? [□] [□] [□] [□] [□]
14. Because of your tinnitus do you find that you are often irritable? [□] [□] [□] [□] [□]
15. Because of your tinnitus, is it difficult for you to read? [□] [□] [□] [□] [□]
16. Does your tinnitus make you upset? [□] [□] [□] [□] [□]
17. Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends? [□] [□] [□] [□] [□]
18. Do you find it difficult to focus your attention away from your tinnitus and on other things? [□] [□] [□] [□] [□]
19. Do you feel that you have no control over your tinnitus? [□] [□] [□] [□] [□]
20. Because of your tinnitus, do you often feel tired? [□] [□] [□] [□] [□]
21. Because of your tinnitus, do you feel depressed? [□] [□] [□] [□] [□]
22. Does your tinnitus make you feel anxious? [□] [□] [□] [□] [□]
23. Do you feel that you can no longer cope with your tinnitus [□] [□] [□] [□] [□]
24. Does your tinnitus get worse when you are under stress? [□] [□] [□] [□] [□]
25. Does your tinnitus make you feel insecure? [□] [□] [□] [□] [□]

Over the past week, what percentage of time were you aware of your tinnitus? ______

During the time you were aware of your tinnitus, what percentage of time was it bothersome? ______
Tinnitus Functional Questionnaire
Adapted from Tinnitus Primary Function Questionnaire

Please indicate your agreement with each statement on a scale from 0 (completely disagree) to 100 (completely agree).

Tinnitus: Internal sounds in your ears or head

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Your score (0-100)</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel like my tinnitus makes it difficult for me to concentrate on some tasks</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I have difficulty focusing my attention on some important tasks because of tinnitus.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>My inability to think about something undisturbed is one of the worst effects of my tinnitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>My emotional peace is one of the worst effects of my tinnitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I am depressed because of my tinnitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I am anxious because of my tinnitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I am tired during the day because my tinnitus has disrupted my sleep</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I lie awake at night because of my tinnitus</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>When I wake up in the night, my tinnitus makes it difficult to get back to sleep</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Hearing loss: Difficulty understanding speech and environmental sounds

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Your score (0-100)</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>It’s hard for me to understand what others are saying in noisy/crowded places</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I have a difficult time understanding what people are saying on television or movies</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>It’s hard for me to participate in group conversations because I can’t understand what others are saying</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sound Sensitivity: Sensitive to external sounds in your environment (NOT tinnitus)

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Your score (0-100)</th>
<th>Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I feel like my sound sensitivity (hyperacusis) makes it difficult for me to enjoy my life</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I must avoid many situations because of my sound sensitivity (hyperacusis)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>My inability to tolerate everyday sounds is one of the worse effects of my sound sensitivity (hyperacusis)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Holmes-Rahe Life Stress Inventory

Complete the following life stress inventory. This will help us to determine how stress may impact your health and be contributing to your tinnitus.

Read each of the events listed below, and check the box next to any event which has occurred in your life in the last 12 months. There are no right or wrong answers. The aim is to identify which events you have experienced lately.

<table>
<thead>
<tr>
<th>Life Events</th>
<th>Change Units</th>
</tr>
</thead>
<tbody>
<tr>
<td>Death of spouse/child</td>
<td>100</td>
</tr>
<tr>
<td>Divorce</td>
<td>73</td>
</tr>
<tr>
<td>Marital separation</td>
<td>65</td>
</tr>
<tr>
<td>Jail term</td>
<td>63</td>
</tr>
<tr>
<td>Death of close family member</td>
<td>63</td>
</tr>
<tr>
<td>Personal injury or illness</td>
<td>53</td>
</tr>
<tr>
<td>Marriage</td>
<td>50</td>
</tr>
<tr>
<td>Fired at work</td>
<td>47</td>
</tr>
<tr>
<td>Marital reconciliation</td>
<td>45</td>
</tr>
<tr>
<td>Retirement</td>
<td>45</td>
</tr>
<tr>
<td>Change in health of a family member</td>
<td>44</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>40</td>
</tr>
<tr>
<td>Sex difficulties</td>
<td>39</td>
</tr>
<tr>
<td>Gain of new family member</td>
<td>39</td>
</tr>
<tr>
<td>Business readjustment</td>
<td>39</td>
</tr>
<tr>
<td>Change in financial state</td>
<td>38</td>
</tr>
<tr>
<td>Death of close friend</td>
<td>37</td>
</tr>
<tr>
<td>Change to different line of work</td>
<td>36</td>
</tr>
<tr>
<td>Change in number of arguments with spouse</td>
<td>35</td>
</tr>
<tr>
<td>Mortgage over $500,000</td>
<td>31</td>
</tr>
<tr>
<td>Foreclosure of mortgage or loan</td>
<td>30</td>
</tr>
<tr>
<td>Change in responsibilities at work</td>
<td>29</td>
</tr>
<tr>
<td>Child leaving home</td>
<td>29</td>
</tr>
<tr>
<td>Trouble with in-laws</td>
<td>29</td>
</tr>
<tr>
<td>Outstanding personal achievement</td>
<td>28</td>
</tr>
<tr>
<td>Spouse begins or stops work</td>
<td>26</td>
</tr>
<tr>
<td>Begin or end school</td>
<td>26</td>
</tr>
</tbody>
</table>
Holmes-Rahe Life Stress Inventory continued

<table>
<thead>
<tr>
<th>Event</th>
<th>Score</th>
<th>(selection)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Change in living conditions</td>
<td>25</td>
<td></td>
</tr>
<tr>
<td>Revision in personal habits</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Trouble with boss</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>Change in work hours or conditions</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Change in residence</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Change in schools</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>Change in recreation</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Change in church activities</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>Change in social activities</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Mortgage or loan less than $100,000</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>Change in sleeping habits</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Change in number of family get-togethers</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Change in eating habits</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>Vacation</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Christmas alone</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Minor violations of the law</td>
<td>11</td>
<td></td>
</tr>
</tbody>
</table>

None of the above apply: 0

Add other stressors you have experienced in the past year that are not included above or additional information you would like to add:

_______________________________________________________________________________________________
_______________________________________________________________________________________________

Fax or Mail Your Form and Records

Send us your completed form and any outside records specifically related to your history of tinnitus — such as hearing tests or office notes. You or your doctor's office may send them via fax or mail to the contact information below.

The Tinnitus and Hyperacusis Program Team
Department of Otolaryngology
Attn: Audiology
9200 W. Wisconsin Avenue
Milwaukee, WI 53226
Phone: 414-805-8569
Fax: 414-269-8157

In addition to tinnitus (internal sounds), some people experience sensitivity to sounds in their environment (external sounds) referred to as hyperacusis or misophonia. If you feel you are sensitive to sounds that others are not sensitive to or are now sensitive to sounds you were able to tolerate in the past, complete the additional forms in the hyperacusis packet.