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HISTORY OF HEARING LOSS

NAME: _____ **DATE:** _____

Type of hearing loss (check all that apply): ___ Sensorineural ___ Conductive ___ Mixed ___ Unknown

___ Sudden ___ Congenital ___ Progressive ___ Fluctuating

First year hearing loss noticed: _____

Cause of hearing loss: _____

_____

Family History of hearing loss: ___ Yes ___ No

If Yes, who: _____

History of loud noise exposure: ___ Yes ___ No If Yes, what: _____

Better hearing ear: ___ Right ___ Left ___ Neither

History of Tinnitus:

History of ear infections/pain/ ear surgery:

History of Dizziness:

Significant Medical History (e.g. diabetes, pace maker, Meniere's etc.):

History of hearing aid use:

Ever worn hearing aids: ___ Yes ___ No

Year first hearing aids fit: _____

How many sets of hearing aids have been used: ___ 1 ___ 2 ___ 3 ___ 4 ___ 5+

Have you worn hearing aids consistently: ___ Yes ___ No

Can you understand speech in the following situations:

Quiet environments: ___ Yes ___ No ___ Sometimes

Small groups (3-5 people): ___ Yes ___ No ___ Sometimes

Large groups (5+ people): ___ Yes ___ No ___ Sometimes

TV without captions: ___ Yes ___ No ___ Sometimes

Over the phone: ___ Yes ___ No ___ Sometimes; Do you have a Cap Tell Phone?

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TINNITUS HANDICAP INVENTORY

NAME: _____ **DATE:** _____

INSTRUCTIONS

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

	Yes	Sometimes	No
1. Because of your tinnitus, is it 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 to sleep at night?			
8. Do you feel as though you cannot escape your tinnitus?			
9. Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?			
10. Because of your tinnitus, do you feel frustrated?			
11. Because of your tinnitus, do you feel that 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?			

FOR CLINICIAN USE ONLY

Total Per Column				
	x4	x2	x0	=
Total Score				

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TINNITUS HANDICAP INVENTORY SECURITY SCALE

Grade	Score	Description
1	0 - 16	Slight: Only heard in quiet environment, very easily masked. No interference with sleep or daily activities.
2	18 - 36	Mild: Easily masked by environmental sounds and easily forgotten with activities. May occasionally interfere with sleep but not daily activities.
3	38 - 56	Moderate: May be noticed, even in the presence of background or environmental noise, although daily activities may still be performed.
4	58 - 76	Severe: Almost always heard, rarely, if ever, masked. Leads to disturbed sleep pattern and can interfere with ability to carry out normal daily activities. Quiet activities affected adversely.
5	78 - 100	Catastrophic: Always heard, disturbed sleep patterns, difficulty with any activity.

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SSQ12 INSTRUCTIONS

NAME: _____ **DATE:** _____

The following questions inquire about aspects of your ability and experience hearing and listening in different situations. For each question, put a mark, such as a cross (x), anywhere on the scale shown against each question that runs from 0 through to 10. Putting a mark at 10 means that you would be perfectly able to do or experience what is described in the question. Putting a mark at 0 means you would be quite unable to do or experience what is described.

As an example, question 1 asks about having a conversation with someone while the TV is on at the same time. If you are well able to do this then put a mark up toward the right-hand end of the scale. If you could follow about half the conversation in this situation put the mark around the mid-point, and so on. We expect that all the questions are relevant to your everyday experience, but if a question describes a situation that does not apply to you, put a cross in the "not applicable" box. Please also write a note next to that question explaining why it does not apply in your case.

NAME:	DATE:	AGE:

PLEASE CHECK ONE OF THESE OPTIONS:

- I have **no** hearing aid/s ☐
- I use **one** hearing aid (**left** ear) ☐
- I use **one** hearing aid (**right** ear) ☐
- I use **two** hearing aids (**both** ears) ☐

IF YOU HAVE BEEN USING HEARING AID/S, FOR HOW LONG?

Left Ear	Right Ear
_____ years	_____ years
_____ months	_____ months
_____ weeks	_____ weeks

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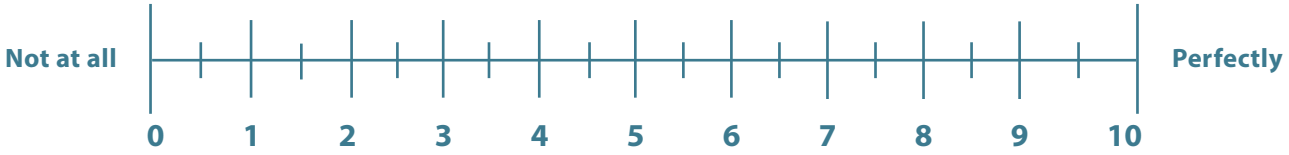
SSQ12 INSTRUCTIONS

1. You are talking with one other person and there is a TV on in the same room. Without turning the TV down, can you follow what the person you're talking to says?



Not applicable ☐

2. You are listening to someone talking to you, while at the same time trying to follow the news on TV. Can you follow what both people are saying?

Not applicable ☐

3. You are in conversation with one person in a room where there are many other people talking. Can you follow what the person you are talking to is saying?

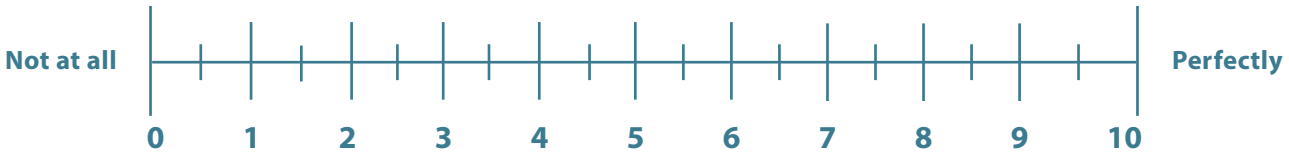
Not applicable ☐

4. You are in a group of about five people in a busy restaurant. You can see everyone else in the group. Can you follow the conversation?

Not applicable ☐

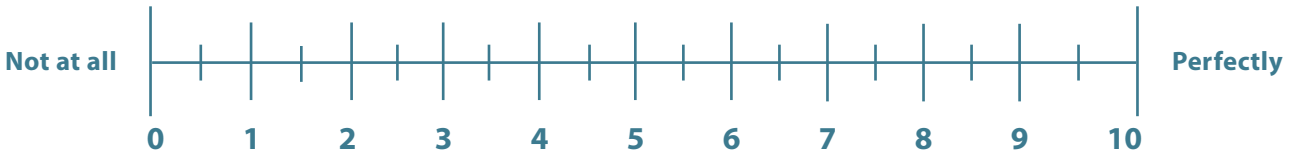
SSQ12 INSTRUCTIONS

5. You are with a group and the conversation switches from one person to another. Can you easily follow the conversation without missing the start of what each new speaker is saying?



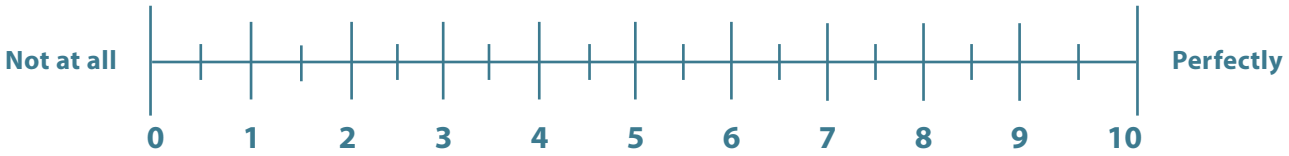
Not applicable ☐

6. You are outside. A dog barks loudly. Can you tell immediately where it is, without having to look?



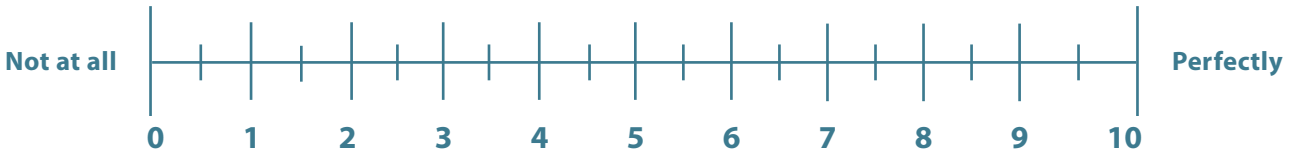
Not applicable ☐

7. Can you tell how far away a bus or a truck is, from the sound?



Not applicable ☐

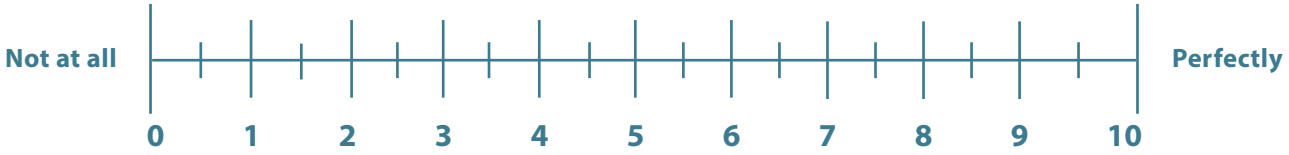
8. Can you tell from the sound whether a bus or truck is coming towards you or going away?



Not applicable ☐

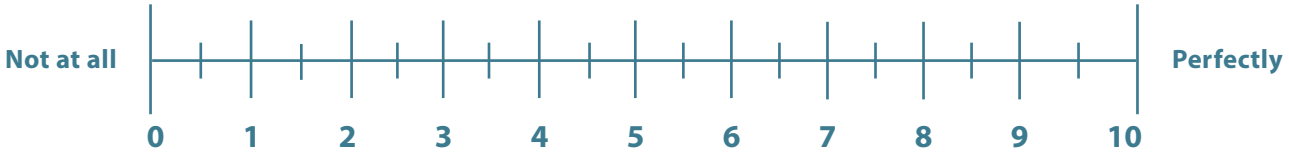
SSQ12 INSTRUCTIONS

9. When you hear more than one sound at a time, do you have the impression that it seems like a single jumbled sound?



Not applicable ☐

10. When you listen to music, can you make out which instruments are playing?



Not applicable ☐

11. Do everyday sounds that you can hear easily seem clear to you (not blurred)?

Not applicable ☐

12. Do you have to concentrate very much when listening to someone or something?

Not applicable ☐

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GERIATRIC DEPESSION SCALE (SHORT FORM)

INSTRUCTIONS

Check the answer that best describes how you felt over the past week.

	Yes	No
1. Are you basically satisfied with your life?		
2. Have you dropped many of your activities and interests?		
3. Do you feel that your life is empty?		
4. Do you often get bored?		
5. Are you in good spirits most of the time?		
6. Are you afraid that something bad is going to happen to you?		
7. Do you feel happy most of the time?		
8. Do you often feel helpless?		
9. Do you prefer to stay at home, rather than going out and doing things?		
10. Do you feel that you have more problems with memory than most?		
11. Do you think it is wonderful to be alive now?		
12. Do you feel worthless the way you are now?		
13. Do you feel full of energy?		
14. Do you feel that your situation is hopeless?		
15. Do you think that most people are better off than you are?		

SCORE _____

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GERIATRIC DEPRESSION SCALE (GDS) SCORING INSTRUCTIONS

INSTRUCTIONS

Score 1 point for each bolded answer. A score of 5 or more suggests depression.

	Yes	No
1. Are you basically satisfied with your life?		
2. Have you dropped many of your activities and interests?		
3. Do you feel that your life is empty?		
4. Do you often get bored?		
5. Are you in good spirits most of the time?		
6. Are you afraid that something bad is going to happen to you?		
7. Do you feel happy most of the time?		
8. Do you often feel helpless?		
9. Do you prefer to stay at home, rather than going out and doing things?		
10. Do you feel that you have more problems with memory than most?		
11. Do you think it is wonderful to be alive now?		
12. Do you feel worthless the way you are now?		
13. Do you feel full of energy?		
14. Do you feel that your situation is hopeless?		
15. Do you think that most people are better off than you are?		

SCORE _____

A score of **> 5** suggests depression

Ref. Yes average: The use of Rating Depression Series in the Elderly, in Poon (ed.): Clinical Memory Assessment of Older Adults, American Psychological Association, 1986