PACIFIC HEAD & NECK℠

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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.

Geriatric Depression Scale (short form)

Instructions: Circle the answer that best describes how you felt over the past week.

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

Total Score _____

Cochlear Implant Quality of Life-35 Profile

ID:_____ **Date:**_____

INSTRUCTIONS: Think about your daily life with your cochlear implant (and/or hearing aid, if you also use one). Answer how often each of the following statements applies to your feelings and experiences. Answer how often each statement applies even if you don't use cochlear implants or hearing aids.

	Never	Rarely	Sometimes	Often	Always
1. I am able to have a conversation in a quiet place without asking the other person to repeat themselves					
2. Other people's voices sound clear and natural to me					
3. I am able to have a conversation with a group of three or more people					
4. I am able to have a conversation without asking the other person to repeat themselves					
5. I can hear and understand without looking at the person speaking					
6. I have to ask a lot of questions about what is being said in a conversation					
7. I can understand a conversation in a crowded environment (restaurant, party, etc.)					
8. I am able to have a conversation with someone in a noisy place without asking them to repeat themselves					
9. I can understand strangers without lip-reading in a noisy place					
10. I can follow the conversation in a group of five people in a crowded restaurant when I cannot see everyone					
11. I feel comfortable being myself					
12. My hearing loss makes me feel inadequate					
13. My hearing loss makes me irritable					
14. I keep quiet in a conversation to avoid saying the wrong thing					
15. I become frustrated when I cannot follow a conversation					

	Never	Rarely	Sometimes	Often	Always
16. My hearing loss prevents me from listening to TV or radio					
17. I am able to enjoy listening to the radio and TV					
18. I am able to enjoy music					
19. I can recognize certain melodies in music					
20. Music sounds clear and natural to me					
21. Everyday sounds (birds chirping, rain, car horns, etc.) are clear to me					
22. Everyday sounds (microwave, birds chirping, rain, car horn) sound natural to me					
23. I am able to distinguish sounds in nature					
24. I am able to hear cars approaching in traffic					
25. I can hear someone approaching from behind					
26. I am able to follow a conversation with minimal effort					
27. I am able to ignore competing sounds and focus on the person who is speaking					
28. I can easily have a conversation in a noisy place (restaurant, party, store)					
29. I have to concentrate when having a conversation					
30. I have to concentrate when having a conversation with strangers when in a noisy place					
31. If I am interested, I will join family or friends for a social event					
32. I have the confidence to socialize					
33. I avoid socializing with friends, relatives, or neighbors due to my hearing loss					
34. I avoid social situations due to my hearing loss					
35. I feel left out when I am with a group of people due to my hearing loss					

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