Welcome to the University of Arizona
Clinic for Adult Hearing Disorders

We look forward to seeing you during your upcoming appointment. At that time, we will have:

- a comprehensive discussion about your ears and hearing, specifically addressing the tinnitus (ringing, buzzing, humming) that you are experiencing,
- a tinnitus assessment including (pitch matching, loudness matching, and masking measurements)
- and a discussion of the test results and our recommendations for management and follow up.

University of Arizona Tinnitus Management Program

Tinnitus is the perception of sound in the ears or head in the absence of an external source. It is often described as ringing, but tinnitus can come in many forms (e.g. buzzing, humming, whoosing, roaring, etc.). The impact of tinnitus is as varied at the forms it takes. For some, tinnitus is an ever present but non-bothersome occurrence. For others, living with tinnitus can be frustrating and upsetting. While there is no "cure" for tinnitus, there have been many successful management options to help those who suffer from tinnitus cope with the condition. Developing a management plan for your tinnitus is a multi-step process based on your specific needs and tinnitus experience.

What Should I Expect at My Tinnitus Consultation?

From the outset, your audiology team will discuss with you your history and explore the potential cause of your tinnitus as well as your general ear/hearing health. It helps to have a comprehensive audiologic evaluation prior to your tinnitus consultation to assist in determining how the status of your hearing may be contributing to your tinnitus experience.

A tinnitus evaluation will be performed in order to document the measurable characteristics of your tinnitus including the pitch, volume, and maskability. These measurements in addition to the information you provide about your medical, hearing, and tinnitus history are valuable in your treatment plan development. After the evaluation, we will discuss the results of testing, implications, and the best management strategies for you. Management strategies vary and are tailored to your needs.

Description of Tinnitus Management Program and Philosophy: At the University of Arizona Hearing Clinic, our goal is to gather as much information about you and your tinnitus as possible in order to develop individualized strategies to reduce your perception of your tinnitus as well as your negative experience of it. This is often done with a combination of education, counseling, ear-level devices and other technologies. We will create a plan addressing areas of need identified during the consultation and follow you through the process.

Important to Note: *Audiologists have a strong clinical background in assessment, diagnostic testing, and interpretation as well as provision of rehabilitative practices relevant to those with ear related impairment. Audiologists are not professional counselors and the counseling provided related to your tinnitus management should not be a substitute for professional behavioral health services.*

YOUR COSTS:

Our Professional Fee: We encourage you to look into your insurance coverage. In most cases, this evaluation fee is not covered by insurance because either it is not a covered benefit or we are not in-network providers. This means that you will be responsible for the cost of service at the time of your appointment.

Service	Professional Fee
Audiologic Evaluation	**$62-$117** (often covered by Medicare & other insurance)
Tinnitus Evaluation	**$120** (often covered by Medicare & other insurance)
Evaluation Consultation Fee	**$120/hr prorated at 15 minute increments** (typically not covered by insurance)
Subsequent Follow-up & Consultations	**$120/hr prorated at 15 minute increments** (typically not covered by insurance)

AN IMPORTANT NOTE TO OUR MEDICARE PATIENTS

Medicare does not cover routine hearing evaluations or evaluations for the purpose of obtaining hearing aids. Medicare will sometimes cover tinnitus evaluations deemed medically necessary by your physician. You are welcome to discuss this with your physician and obtain a referral, but please note that you may still be responsible for the cost of your hearing evaluation even with a referral if medical necessity is not evident from the wording of the referral.

Respectfully

Clinical Faculty
University of Arizona Hearing Clinic

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UNIVERSITY OF ARIZONA HEARING CLINIC
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Audiology Case History – ADULT TINNITUS PATIENT

NAME:____ DATE:_________________________

DATE OF BIRTH:_________________ AGE:__________ PHONE: _______________________________________

ADDRESS:____

EMAIL ADDRESS: ____

OCCUPATION or FORMER OCCUPATION:____

SPOUSE/SIGNIFICANT OTHER'S NAME: ____

REFERRED BY:____

Describe your Tinnitus

1. **How would you describe your tinnitus?** ____

   (ringing, buzzing, humming, whooshing, hissing, clicking, popping, whistling, roaring, noise, crickets, etc.)

2. **Please describe the pitch of your tinnitus?**

   _____Very High Pitched _____High Pitched _____Medium Pitched _____Low Pitched

3. **Which ear is impacted?** _______Right ________Left _________Both with Left = Right

   ______ Both with Left worse than Right ______ Both with Right worse than left _____Central

4. **Is the tinnitus constant or intermittent?** ____

5. **Does your tinnitus pulsate?** ____Yes with heart beat ____Yes different from heart beat ____No

6. **Does the loudness of your tinnitus vary?** _____Yes ______No

7. **Is there anything that makes the tinnitus worse?** ____

8. **Is there anything that makes the tinnitus better?** ____

Tinnitus History

1. **When did you first become aware of the tinnitus?** ____

2. **When did your tinnitus first become disturbing/bothersome?** ________________________________

3. **Can you recall a triggering or precipitating event that led up to the onset of your tinnitus?** *(i.e. loud noise, whiplash, change in hearing, stress, head trauma, medication/surgery, dental work)*

   ____

4. **How did you initially perceive the tinnitus?** ______Gradual ______Abrupt

5. **Have you consulted any other specialists or doctors regarding the tinnitus?** ______________________

6. **What advice or information have you received?** ____

7. **What treatments have you tried for your tinnitus?**

   _______None _______Hearing Aids ________Masking Devices ______TRT

   ______Counseling _______Music Therapy ________Medications ______Other

8. **How successful did you find these treatments?** ____

Have you ever:

Been exposed to gunfire/explosion?	Yes	No
Attending loud events (clubs, concerts etc.)?	Yes	No
Had any noisy jobs (factory, mechanics, welding etc.)?	Yes	No
Had any noisy hobbies or home activities (motorcycles, ATV, power tools etc.)?	Yes	No
Been or are you currently a musician?	Yes	No
Had any head injuries or concussions?	Yes	No
Had any operations to your head/neck/ears?	Yes	No
Used solvents, thinners or alcohol based cleaners?	Yes	No
Taken the following medications: Quinine, Quinidine, Streptomycin, Kanamycin, Dihydrostreptomycin, Neomycin, Chemotherapy	Yes	No

Do you:

Notice a change in your tinnitus due to head or neck movements (e.g. moving the jaw forward or clenching your teeth) or having your head, arms or hands touched?	Yes	No
Have an exacerbation of tinnitus when in the presence of loud noise?	Yes	No
Have a problem tolerating sounds because they often seem much too loud? That is, do you often find sounds to be too loud even though others around you seem unaffected?	Yes	No
Receive treatment or care for psychiatric problems?	Yes	No
Regularly take aspirin?	Yes	No
Have any feelings of ear pressure or blockage?	Yes	No
Suffer from headaches?	Yes	No
Suffer from dizziness or vertigo?	Yes	No
Suffer from temporomandibular jaw disorder (TMJ)?	Yes	No
Suffer from neck pain or back problems?	Yes	No
Suffer from other pain syndromes?	Yes	No
Have loose dentures, jaw pain, or grinding/clicking sensations in the jaw?		

General Hearing Questions

Do you wear hearing aids?	Yes	No
Do you have any difficulties hearing when in background noise is present?		
Do you have difficulties understanding in one-on-one conversations?	Yes	No
Do you have difficulties hearing the television?	Yes	No
Do you have difficulties hearing on the phone?	Yes	No

Impact of Tinnitus

1. **How does your tinnitus affect your work?** ____

   ____
2. **How does your tinnitus affect your home life?** ____

   ____
3. **How does your tinnitus affect your social activities?** ____

   ____
4. **How does your tinnitus affect your sleep?** ____

   ____
5. **Is there anything else you would like to add that might be helpful for us to know about the cause or impact of your tinnitus**? ____

   ____

______________________________ ______________________________

Signature of Person Answering Questions Relationship to Patient

TINNITUS FUNCTIONAL INDEX

Today's Date ______________ Your Name ______________________
Month / Day / Year *Please Print*

Please read each question below carefully. To answer a question, select *ONE* of the numbers that is listed for that question, and draw a *CIRCLE* around it like this: (10%) or (1).

I — Over the PAST WEEK...

1. What percentage of your time awake were you consciously **AWARE OF** your tinnitus?

Never aware ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◄ *Always aware*

2. How **STRONG** or **LOUD** was your tinnitus?

Not at all strong or loud ►0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely strong or loud*

3. What percentage of your time awake were you **ANNOYED** by your tinnitus?

None of the time ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◄ *All of the time*

SC — Over the PAST WEEK...

4. Did you feel **IN CONTROL** in regard to your tinnitus?

Very much in control ►0 1 2 3 4 5 6 7 8 9 10 ◄ *Never in control*

5. How easy was it for you to **COPE** with your tinnitus?

Very easy to cope ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Impossible to cope*

6. How easy was it for you to **IGNORE** your tinnitus?

Very easy to ignore ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Impossible to ignore*

C — Over the PAST WEEK...

7. Your ability to **CONCENTRATE**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Completely interfered*

8. Your ability to **THINK CLEARLY?**

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Completely interfered*

9. Your ability to **FOCUS ATTENTION** on other things besides your tinnitus?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Completely interfered*

SL — Over the PAST WEEK...

10. How often did your tinnitus make it difficult to **FALL ASLEEP or STAY ASLEEP**?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Always had difficulty*

11. How often did your tinnitus cause you difficulty in getting **AS MUCH SLEEP** as you needed?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Always had difficulty*

12. How much of the time did your tinnitus keep you from **SLEEPING** as **DEEPLY** or as **PEACEFULLY** as you would have liked?

None of the time ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *All of the time*

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Please read each question below carefully. To answer a question, select *ONE* of the numbers that is listed for that question, and draw a *CIRCLE* around it like this: (10%) or (1).

A	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere* ▼										*Completely interfered* ▼
	13. Your ability to **HEAR CLEARLY**?	0	1	2	3	4	5	6	7	8	9	10
	14. Your ability to **UNDERSTAND PEOPLE** who are talking?	0	1	2	3	4	5	6	7	8	9	10
	15. Your ability to **FOLLOW CONVERSATIONS** in a group or at meetings?	0	1	2	3	4	5	6	7	8	9	10
R	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere* ▼										*Completely interfered* ▼
	16. Your **QUIET RESTING ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
	17. Your ability to **RELAX**?	0	1	2	3	4	5	6	7	8	9	10
	18. Your ability to enjoy "**PEACE AND QUIET**"?	0	1	2	3	4	5	6	7	8	9	10
Q	**Over the PAST WEEK, how much has your tinnitus interfered with...**	*Did not interfere* ▼										*Completely interfered* ▼
	19. Your enjoyment of **SOCIAL ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
	20. Your **ENJOYMENT OF LIFE**?	0	1	2	3	4	5	6	7	8	9	10
	21. Your **RELATIONSHIPS** with family, friends and other people?	0	1	2	3	4	5	6	7	8	9	10

22. How often did your tinnitus cause you to have difficulty performing your **WORK OR OTHER TASKS**, such as home maintenance, school work, or caring for children or others?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Always had difficulty*

E **Over the PAST WEEK...**

23. How **ANXIOUS** or **WORRIED** has your tinnitus made you feel?

Not at all anxious or worried ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely anxious or worried*

24. How **BOTHERED** or **UPSET** have you been because of your tinnitus?

Not at all bothered or upset ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely bothered or upset*

25. How **DEPRESSED** were you because of your tinnitus?

Not at all depressed ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely depressed*

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PATIENT HEALTH QUESTIONNAIRE-9: SCREENING INSTRUMENT FOR DEPRESSION

OVER THE PAST TWO WEEKS, HOW OFTEN HAVE YOU BEEN BOTHERED BY ANY OF THE FOLLOWING PROBLEMS?	*NOT AT ALL*	*SEVERAL DAYS*	*MORE THAN HALF THE DAYS*	*NEARLY EVERY DAY*
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3
Trouble falling or staying asleep, or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
	0	1	2	3
	Total:	____+	____+	____

Name: ____ Date: __________________

Please provide us with the following information regarding your current medications, including prescription, over-the-counter, herbals, vitamin/mineral/dietary (nutritional) supplements. If you have a pre-printed list, we are happy to make a copy of that instead.

Medication	**Dose**	**How Often**	**How Taken** (pill, enhaler, etc)	**Condition Taken For**

If you anticipate you may be a candidate for hearing aids or other devices, please answer the additional questions

NAME: ____ DATE: ______________________

Please complete the following. Be as honest and precise as possible.

Our goal is to best understand your communication needs, personal preferences, and expectations in order to recommend a hearing solution that is most appropriate for you.

1. Below, please indicate how well you hear in the following situations and how often you are in each of these situations.
   Note: If you already wear hearing aids, please answer these questions assuming you are wearing your hearing aids.

Listening situation	How well do you hear in this situation?			How often are you in this situation?		
	Poor	**Fair**	**Good**	**Rarely**	**Sometimes**	**Often**
Quiet room (1-2 people)	☐	☐	☐	☐	☐	☐
Meetings	☐	☐	☐	☐	☐	☐
Restaurants	☐	☐	☐	☐	☐	☐
Large social gathering	☐	☐	☐	☐	☐	☐
Television	☐	☐	☐	☐	☐	☐
Telephone	☐	☐	☐	☐	☐	☐
Outdoors (i.e. wind noise)	☐	☐	☐	☐	☐	☐
In the car	☐	☐	☐	☐	☐	☐
Listening to music	☐	☐	☐	☐	☐	☐
Other:________________________	☐	☐	☐	☐	☐	☐
Other:________________________	☐	☐	☐	☐	☐	☐

2. List the top 3 situations you would most like to hear better.
   ____
   ____
   ____

3. On a scale of 1 to 10, how well do you think a new hearing system will improve your hearing? Mark an "x" on the line. I expect it to:
   Not be helpful at all 1……………………………………………………………10 *Greatly improve my hearing*

4. What is your most important consideration regarding hearing aids? Please rank the following factors with 1 as the most important and 4 as the least important.
   ________*Hearing aid size and the ability of others not to see them.*
   ________*Improved ability to hear and understand speech.*
   ________*Improved ability to understand speech in noisy situations (e.g. restaurants, parties).*
   ________*Cost of the hearing system.*

5. Do you think you prefer hearing devices that (check one):
________are automatic so that you do not have to make adjustments to them.
________allow you to adjust the volume and change the listening programs as you see fit.
________no preference.

6. How much would it bother you if other people could see your hearing aids? Mark an "x" on the line.
Not at all 1……………………………………….5…………………………………….10 *Quite a lot*

7. How motivated are you to use assistive technology to hear better? Mark an "x" on the line.
Not very motivated 1……………………………………….5…………………………………….10 *Very motivated*

8. Please look below and check any of the following that apply to you:

☐ Dexterity issues ☐ Pacemaker ☐ Smart phone user ☐ Have a landline phone
☐ Difficulty hearing doorbell/alarms ☐Moisture/perspiration ☐Wax issues

☐ I would like more info about communication tips/strategies for family and friends.
☐ I would like more info about laws that provide accessibility to people with hearing loss.
☐ I would like more info about hearing loss support groups.
☐ I would like more info about aural rehabilitation classes.

9. Do you have any previous experiences with hearing instruments? Please describe.
____
____
____

10. Is there anything else you would like us to know? _________________________________
____

*The above was partially adapted from Taylor (2012) and Thibodeau (2004). EMH 2015.

Tobacco Use and Hearing and Balance Disorders

What Patients Need to Know

Recent data from the Centers for Disease Control (CDC) report that 17.8% of American adults (age 18 or older) smoke. This translates into an estimated 42.1 million adults in the US alone.

Cigarette smoking is the leading cause of preventable disease, responsible for 480,000 deaths a year (approximately 1/5).

Smoking increases the risk of:

- Coronary heart disease
- Stroke
- Cancer, including but not limited to:
    - Lung
    - Stomach
    - Leukemia
    - Bladder, kidney, cervix, colon
    - Kidney, liver, pancreas
    - Esophagus, trachea, larynx, throat, tongue

Smoking has been correlated to hearing loss, especially when combined with noise exposure.

To Quit Tobacco Use:

The AQC recommends discussing all treatment options for smoking and/or tobacco cessation with your physician. Some possible treatment recommendations from a physician may include:

- Individual or group counseling.
- Behavioral therapies
- Medications for quitting that have been found to be effective include the following:
    - Nicotine replacement products
        - Over-the-counter
        - Prescription
    - Prescription non-nicotine medications

Helpful Resources

- Quitline Services
    - Call 1-800-QUIT-NOW (1-800-784-8669) if you want help quitting. This is a free telephone support service that can help people who want to stop smoking or using tobacco.
- Smokefree.gov
    - http://smokefree.gov
- American Cancer Society
    - http://www.cancer.org/healthy/stayawayfromtobacco/guidetoquittingsmoking/guide-to-quitting-smoking-toc
- American Lung Association
    - Call 1-800-LUNGUSA
    - http://www.lung.org/stop-smoking/