Misophonia Management Program Case History

Patient Name: ________________________________DOB:___________ Today's Date: __________

Reason for today's appointment: ____

Where are you employed (if a student, where do you go to school)? ___________________________

Medical History: (Please include any significant events, accidents, surgeries, ages when these occurred, or inherited conditions, congenital disorders, or family history related to auditory function.)

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____

____

Age of Onset of Symptoms: (Please note the first memory-description of triggers.) _______________

____

____

____

Any treatment tried in the past: ____

____

Effectiveness of above treatment: ____

____

Worse Scenarios-Triggers: (Please list the main sounds that cause problems.) __________________

____

____

____

Is there someone that is associated with the worst-case triggers: _______________________________

____

Worse scenario reactions: (Please list the reactions experienced or expressed to the above triggers: self-harm, flight, verbal or body expressions of anger, frustration, rage, sorrow, confusion, etc.

____

____

Length of time required for recovery from reactions:

____

Activities or actions that can affect the reactions, either the intensity of reactions or the duration of the reaction:

____

____

Best case scenario: (What activities are the most comfortable for the patient, when are they the happiest?)

____
____
____
____

Are earplugs used? ______ How often? ______ Ear muff? _____ Noise cancellation devices? _____

Family/friends living with the patient: ____
____

What daily living activities are affected: ____
____

What is the impact on the other members of the other members of the household? _______________
____
____

Hobbies, interests: ____

Have you ever been exposed to loud noise? ☐ Yes ☐ No
If yes, describe the type of noise: ____

Is there a family history of hearing loss? ☐ Yes ☐ No Who:
____

Have you ever had ear surgery? ☐ Yes ☐ No
What was the surgery? ____
Have you ever had any head/ear trauma? ☐ Yes ☐ No What was the trauma? ______________
____

Have you ever taken medication that had a toxic effect on your hearing? ☐ Yes ☐ No
What was the toxic medication?
____

*Have you experienced any drainage from your ears within the last 90 days? ☐ Yes ☐ No
Which ear did you have drainage? ☐ Right ☐ Left
*Do you suffer from pain or discomfit in your ears? ☐ Yes ☐ No ☐ Right ☐ Left
Do you have temporomandibular joint (TMJ) disorder? ☐ Yes ☐ No ☐ Right ☐ Left
Do you have a congenital or traumatic deformity of the ear? ☐ Yes ☐ No Please explain:
____
____

Do you have ringing, roaring, buzzing (tinnitus)? ☐ Yes ☐ No ☐ Right ☐ Left
If present, is it: Constant ____ Intermittent ___ When did you first notice tinnitus?____________
What does it sound like? ____
Do you have significant cerumen (earwax) accumulation in your ear canal? ☐ Yes ☐ No
☐ Right ☐ Left
*Do you suffer from acute or chronic dizziness? ☐ Yes ☐ No __________________________

Are you diabetic? ☐ Yes ☐ No
*Do you have headaches? ☐Yes ☐No
*Do you have blurry vision? ☐Yes ☐No
*Do you have nausea or vomiting? ☐Yes ☐No
Do you smoke? ☐Yes ☐No; Have you ever smoked? ☐Yes ☐No; How long? _____________
How many packs a day? ______

Do you have good days and bad days in regards to sound sensitivity: __________________________

What medical providers have been consulted: ____
____

What advice was received prior to this time: ____
____
____

Other related conditions/behaviors/sensitivities: ____
____

Please note any other problems related to sensory dysfunction or disorders: ___________________
____
____

What would you like to see happen as a result of this appointment: ___________________________
____
____

Current medications: Please use an additional page if necessary

NAME OF DRUG	DOSE	HOW OFTEN (ex. once per day)	ROUTE (example orally)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			