

Initial Tinnitus Questionnaire

Patient Name: _____ **Date:** _____

Reason for today's appointment: _____

Allergies to any medications, plastics, etc.? _____

Current medications: _____

Ear Health History

Have you been exposed to loud sounds/noise? Yes No If yes, explain _____

Have you ever had ear surgery? Yes No If yes, ear? Right Left type? _____

Have you ever had any head/ear trauma? Yes No If yes, explain _____

Have you ever taken medication that had a toxic effect on your hearing? Yes No If yes, type? _____

*Have you experienced any drainage from your ear(s) within the last 90 days? Yes No

If yes, Right Left Both

*Do you suffer from pain or discomfort in your ear(s)? Yes No

If yes, Right Left Both

Do you have temporomandibular joint (TMJ) disorder? Yes No

If yes, Right Left Both

Do you have a congenital or traumatic deformity of the ear? Yes No

If yes, describe: _____

Do you often have significant cerumen (earwax) accumulation in your ear canal?

Right Left Both Neither

*Do you suffer from acute or chronic dizziness? Yes No

Please list all major surgeries (Past 10 years):

Please list any serious illnesses (Past 10 years):

Are you diabetic? Yes No

Do you have high blood pressure? Yes No

Initial Tinnitus Questionnaire

Tinnitus

Tinnitus refers to any kind of sound in your head...ringing, hissing and so on. Think only about your tinnitus in regard to the following questions.....

How does the tinnitus sound? _____ Constant? Intermittent?

In which ear is your tinnitus? Right Left Both Head Other

How long ago did you notice the tinnitus? Recently 1-3 years 3-10 years More than 10 years

Do you remember the onset of your tinnitus? Yes No

Was it a sudden or progressive onset? Sudden Progressive

Was it related to any other medical or environmental condition? Yes No

*Does your tinnitus pulse with your heartbeat? Yes No

*Is your tinnitus triggered by head or neck movement? Yes No

Is there any one in your family who has/had tinnitus? Yes No

Have you consulted any other professional or tried any treatment for your tinnitus? Yes No

If yes, explain _____

Does your tinnitus....

| | | | |
|--|--------|-----------|-------|
| Make it difficult to fall asleep? | always | sometimes | never |
| Make it difficult to concentrate while reading? | always | sometimes | never |
| Make it difficult to relax in a quiet room? | always | sometimes | never |
| Make it difficult to focus your attention away from your tinnitus? | always | sometimes | never |
| Cause you to feel angry? | always | sometimes | never |
| Cause you to feel stressed? | always | sometimes | never |
| Cause you to feel sad? | always | sometimes | never |

Office Use Only (2)___ (1)___ (0)___ Total _____

Sound Tolerance

Sound tolerance refers to how you react to sounds in your environment. Think only about your sound tolerance in regard to the following questions.....

Do you use ear protection (earplugs or earmuffs) specifically for tinnitus? Yes No

Do you have a decreased tolerance to sound (are sounds bothersome to you when they seem normal to other people around you)? Yes No

Does sound in your environment....

| | | | |
|--|--------|-----------|-------|
| Cause an increase in your tinnitus? | always | sometimes | never |
| Cause you to avoid going certain places? | always | sometimes | never |
| Cause you to feel irritated? | always | sometimes | never |

Initial Tinnitus Questionnaire

Hearing

Hearing refers to your ability to detect sounds in your environment or your ability to understand the speech of other. Think only about your hearing in regard to the following questions...

When was your last hearing exam? _____ By whom? _____

What were the results? _____ Recommendations? _____

Have you ever worn hearing aids? Yes No

*Have you experienced a sudden hearing loss? Yes No

Does your hearing....

Limit or hamper your personal or social life? always sometimes never

Cause you to hear people but not understand what they are saying? always sometimes never

What do you consider is your main problem? Hearing Tinnitus Sound tolerance

If you answered "tinnitus" as your main problem...

What percent of the time are you aware of it? _____

How strong, or loud was your tinnitus, on average, over the last month? "0" would be "no tinnitus and "10" would be "as loud as you can imagine."

(Severity)

1 2 3 4 5 6 7 8 9 10

How much has tinnitus annoyed you, on average, over the last month? "0" would be "not annoying at all" and "10" would be "as annoying as you could imagine." (Annoyance)

1 2 3 4 5 6 7 8 9 10

How much did tinnitus impact your life, over the last month? "0" would be "not at all"; "10" would be "as much as you could imagine." (Effect)

1 2 3 4 5 6 7 8 9 10

Have you experienced any stressful events within the last 12 months?

Additional Information:

TH Inventory (Newman et al)

Instructions: The purpose of the questionnaire is to identify difficulties that you may experience because of your tinnitus. Please answer YES, SOMETIMES or NO, to each question. Please DO NOT SKIP Any Questions.

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

F _____ C _____ E _____ T _____