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  □ Both 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___________________________________________

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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_________

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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

Socio-Emotional

Over the past 2 weeks how often have you been bothered by any of the following?

<table>
<thead>
<tr>
<th></th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
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</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<tr>
<td>2. Feeling down, depressed or hopeless.</td>
<td>0</td>
<td>1</td>
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Hearing

Hearing refers to your ability to detect sounds in your environment or your ability to understand speech. 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)

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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)

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</table>

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)

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Initial Tinnitus Questionnaire

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

How do you feel about your tinnitus?
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________