Northeast Houston Hearing Services

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Hearing Matters

TINNITUS PATIENT SCREENING TOOL

Name: _____ Date: _____

Please circle the response that most accurately reflects your feelings about your tinnitus.
(1=Not often, 5 = Very often)

How often do you feel frustrated by your tinnitus?	1 2 3 4 5
How often does your tinnitus make it difficult for you to concentrate or focus?	1 2 3 4 5
How often does your tinnitus negatively affect your sleeping habits?	1 2 3 4 5
How often does your tinnitus negatively impact your life?	1 2 3 4 5
How often does your tinnitus affect your family/social relationships?	1 2 3 4 5

If someone could help you understand your tinnitus better, would you be interested? Yes No