**Tinnitus History Questionnaire**

Name: ____________________________________________________________ Date: _____________________________

Date of Birth: ____________________ Age: __________

1. Family history of tinnitus complaints? ___Yes ___No If yes, who? __________________________________________

2. When did you first experience your tinnitus? ____________________________________________________________

3. How did you perceive the beginning? ____ Gradual ____Abrupt

4. Was the initial onset of your tinnitus related to:
   ____ Loud blast of sound  ____Whiplash  ____Change in hearing  ____Stress
   ____Head Trauma  ____Others: __________________________________________

5. Does your tinnitus seem to PULSATE?
   ____YES with heartbeat  ____Yes, different from heartbeat  ____No

6. Where do you perceive your tinnitus? ____Right ear  ____Left ear  ____Both ears, worse in left
   ____Both ears, worse in right  ____Both ears, equally  ____Inside the head  ____Elsewhere

7. How does your tinnitus manifest itself over time? ____Intermittent  ____Constant

8. Does the LOUDNESS of the tinnitus vary from day to day? ____Yes  ____No

9. Describe the LOUDNESS of your tinnitus using a scale from 1-100. (1=Very Faint; 100=Very Loud)__________

10. Please describe what your tinnitus usually sounds like: ____________________________________________________

11. Does your tinnitus sound more like a tone or more like noise: ________________________________________________

12. Describe the PITCH of your tinnitus:
   ____Very high frequency  ____High frequency  ____Medium frequency  ____Low frequency

13. Over the last month, what percent of your total awake time have you been aware of your tinnitus?
    __________% (Please write in a single number between 1 and 100)

14. Over the last month, what percent of your total awake time have you been annoyed, distressed, or irritated by your tinnitus? __________% (Please write in a single number between 1 and 100)
15. How many different treatments have you undergone because of your tinnitus?
   ___None  ___One  ___Several  ___Many

16. Is your tinnitus reduced by music or by certain types of environmental sounds such as the noise of a waterfall or
   the noise of running water when you are standing in the shower? ___Yes  ___No  ___Don’t Know

17. Does the presence of loud noise make your tinnitus worse? ___Yes  ___No  ___Don’t Know

18. Does any head and movement (e.g. moving the jaw forward or clenching the teeth), or having your arms/hands
   or head touched, affect your tinnitus? ___Yes  ___No  ___Don’t Know

19. Does taking a nap during the day affect your tinnitus? ___Worsens  ___Reduces  ___Has No Effect

20. Is there any relationship between sleep at night and your tinnitus during the day?
   ___Yes  ___No  ___Don’t Know

21. Does stress influence your tinnitus? ___Worsens  ___Reduces  ___Has No Effect

22. Does medication have an effect on your tinnitus?

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23. Do you think you have a hearing problem? ___Yes  ___No

24. Do you wear hearing aids? ___Right  ___Left  ___Both  ___None

25. Do you have a problem tolerating sounds because they seem too loud? That is, do you often find too loud or
   hurtful sounds which other people around you find comfortable?
   ___Never  ___Rarely  ___Sometimes  ___Usually  ___Always

26. Do sounds cause you pain or physical discomfort? ___Yes  ___No  ___Don’t Know

27. Do you suffer from any of the following: ___Vertigo or Dizziness  ___Temporomandibular Joint Disorder (TMJ)
   ___Headaches  ___Neck Pain  ___Other Pain Syndromes

28. Are you currently under treatment for psychiatric problems? ___Yes  ___No