



Tinnitus History Questionnaire

Name: _____

DOB: _____

Date Completed: _____

General History

When was your last hearing exam? _____

By whom? _____

What were the recommendations? _____

How long ago did you notice a decline in you hearing?

☐ Within past 90 days ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ 10+ years

Have you ever used assistive listening devices? ☐ Yes ☐ No

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

Has anyone in your family suffered hearing loss? ☐ Yes ☐ No

Nature of the Tinnitus

How does the tinnitus sound? _____

Usual site of the tinnitus? ☐ Left worse than Right ☐ Right worse than Left

☐ Left=Right ☐ Central

My tinnitus is: Constant Intermittent

Does the tinnitus fluctuate in intensity? ☐ Yes ☐ No

If yes, is there a pattern? _____

What makes your tinnitus worse? _____

What makes your tinnitus better? _____

Tinnitus History

When did you first become aware of your tinnitus? _____

When did your tinnitus first become disturbing? _____

Under what circumstances did the tinnitus start? _____

What do you consider to have started the tinnitus? _____

Who have you consulted about your tinnitus? _____

What have previous professionals said your tinnitus is due to? _____

What treatments have you tried for your tinnitus? ☐ None ☐ Hearing Aid
☐ Masker ☐ TRT ☐ Counseling ☐ Music Therapy ☐ Other-please

Please explain: _____

How successful did you find these treatments? _____

Hearing Risk Assessment

If yes to any of the following questions, please explain.

Have you ever?

Been exposed to gunfire or explosion ☐ Yes ☐ No

Attended loud events e.g. music concerts or clubs ☐ Yes ☐ No

Had any noisy jobs ☐ Yes ☐ No

Had any noisy hobbies or home activities ☐ Yes ☐ No

Had any head injuries or concussion ☐ Yes ☐ No

Had any operations involving your ear/s or head ☐ Yes ☐ No

Taken any of the following medications:

Quinine, Quindidine, Streptomycin, Kantamycin,
Dihydrostreptomycin, Neomycin ☐ Yes ☐ No

Used solvents, thinners or alcohol based cleaners? ☐ Yes ☐ No

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Do you?

Have loose dentures, jaw pain or grinding
and clicking sensations in the jaw

[] Yes

[] No

Regularly take aspirin?

[] Yes

[] No

How much? _____

Do you find exposure to moderately loud
sounds makes your tinnitus worse?

[] Yes

[] No

Do you currently work?

[] Yes

[] No

What is your current occupation? _____

What hours do you typically work? _____

General Hearing

Is it difficult for you to converse on the telephone?

A

S

N

Do others complain that you turn up the television
or radio too loud?

A

S

N

Do you have difficulty following conversation in
a restaurant?

A

S

N

Does your hearing limit or hamper your personal
or social life?

A

S

N

Do you have to ask people to repeat themselves?

A

S

N

Do you have difficulty hearing when you are in the
the presence of background noise?

A

S

N

Do you have difficulty hearing women's or children's
voices?

A

S

N

Do you hear people, but fail to understand what
they are saying?

A

S

N

Do you feel as though others mumble?

A

S

N

Do you feel stressed or tired when listening for long
periods of time?

A

S

N

Do you have any dizziness or balance problems?

A

S

N

Do you find external sounds unpleasant or
uncomfortable?

A

S

N

Tinnitus History Questionnaire

Do you dislike certain external sounds?

A

S

N

Do you wear ear protection/ear plugs when exposed to loud noises?

A

S

N

Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3)

☐ Hearing Loss

☐ Tinnitus

☐ Sensitivity to Loud Sounds

Effect of the Tinnitus

Over the past week, what percentage of the time you were awake were you aware of your tinnitus (e.g. 100% aware all the time, 25% aware ¼ of the time)?

Details/Comments

[] % _____

What percentage of the time was it disturbing?

[] % _____

Does your tinnitus prevent you from getting to sleep at night?

☐ Yes

☐ No

How many times per night did you awake in last week?

[] Times

How has tinnitus affected your work life? _____

How has tinnitus affected your home life? _____

How has tinnitus affected your social activities? _____

General Health

If yes to any of the following questions, please explain.

What is your general health like? _____

Are you currently being treated for any medical conditions?

☐ Yes

☐ No

Please explain: _____

List any medications you are currently taking or have taken in the last year: _____

Tinnitus History Questionnaire

Do you have allergies to any medications, plastics, etc.? _____

Are you currently taking any food or nutritional/herbal supplements? ☐ Yes ☐ No

Please explain: _____

Has your doctor recommended you follow a special diet? ☐ Yes ☐ No

Please explain: _____

Are you currently following this diet? ☐ Yes ☐ No

If not, please explain why; If yes, explain what changes you are making: _____

How much water do you drink daily? _____

Do you limit your salt/sodium intake? ☐ Yes ☐ No

Do you read food labels? ☐ Yes ☐ No

What do you look for? _____

How much caffeine do you consume daily?

☐ Coffee ☐ Chocolate ☐ Energy drinks
☐ Soda ☐ Tea ☐ Etc.

How much artificial sweeteners do you consume daily?

☐ Diet soda ☐ Sugar-free products

Which sweeteners do you use?

☐ Saccharine ☐ Splenda ☐ Agave
☐ Nutrasweet ☐ Stevia ☐ Sweet n Low
☐ Sugar ☐ Other

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks/wk: _____

Do you use tobacco? ☐ Yes ☐ No

Amount/day: _____

How long have you used tobacco? _____

If you quit, when? _____

Do you use drugs? ☐ Yes ☐ No

Please explain: _____

Have you ever been diagnosed with an eating disorder? ☐ Yes ☐ No

Please explain: _____

☐ Diabetes ☐ Radiation therapy to local area ☐ Compromised immune system
☐ TMJ ☐ Chemotherapy within 6 months ☐ Cognitive ability

Tinnitus History Questionnaire

Have you ever had ear surgery? ☐ Yes ☐ No ☐ Left ☐ Right

Please explain: _____

Please list all major surgeries and illnesses (past 10 years)_____

Do you have regular MRIs? ☐ Yes ☐ No

Please explain: _____

Sleep

When do you go to bed? [] AM/PM Workdays [] AM/PM Weekends

How soon do you fall asleep? _____

How many times do you wake up from sleep? _____

What seems to wake you up? _____

How long does it take to fall back to sleep? _____

When do you wake up in the morning? ☐ AM/PM Workdays ☐ AM/PM Weekends

Do you need an alarm to wake you? _____

When do you get up in the morning? [] AM/PM Workdays [] AM/PM Weekends

Do you feel refreshed or well rested when you wake up? _____

Do you take naps? ☐ Yes ☐ No

When? _____

How long? [] Minutes/Hours

What medications, herbs, teas, etc. do you take to help you sleep? _____

Sleep Environment

Do you sleep:

☐ Alone ☐ With someone in the same room ☐ With someone in the same bed

Has there been a change in your sleeping arrangements recently? (Because of death, divorce, illness or other reasons?) _____

What size and type of bed do you sleep in? _____

Is it comfortable? _____

Is your bedroom: ☐ Cool ☐ Quiet ☐ Dark

Besides sleeping, what other activities do you do in the bedroom?

☐ Watch TV ☐ Read ☐ Eat ☐ Do paperwork ☐ Exercise

[] Other _____

Exercise

Do you currently exercise? ☐ Yes ☐ No

List type, duration, frequency, and intensity of exercise activities: _____

Have you exercised in the past year? ☐ Yes ☐ No

List when, type, duration, frequency, and intensity of exercise activities: _____

Do you have any physical conditions that limit your ability/safety to exercise?

☐ Yes ☐ No

Please explain: _____

Lifestyle

Please list your current stresses: _____

What are your hobbies or interests? _____

Compensation

Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claim or any other legal action in relation to your tinnitus? ☐ Yes ☐ No

Please explain: _____

Medical Contact Details

Name and Address of GP: _____

Name and Address of ENT: _____

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I give consent to release my results to my GP/ENT

Signed

Date

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus? _____

Tinnitus Reaction Questionnaire

Name _____

Date Completed _____

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that **best reflects** how your tinnitus has affected you **over the past week**.

	Not at all	A little of the time	some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy.	0	1	2	3	4
2. My tinnitus has made me feel tense.	0	1	2	3	4
3. My tinnitus has made me feel irritable.	0	1	2	3	4
4. My tinnitus has made me feel angry.	0	1	2	3	4
5. My tinnitus has led me to cry.	0	1	2	3	4
6. My tinnitus has led me to avoid quiet situations.	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out.	0	1	2	3	4
8. My tinnitus has made me feel depressed.	0	1	2	3	4
9. My tinnitus has made me feel annoyed.	0	1	2	3	4
10. My tinnitus has made me feel confused.	0	1	2	3	4
11. My tinnitus has "driven me crazy".	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life.	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate.	0	1	2	3	4
14. My tinnitus has made it hard for me to relax.	0	1	2	3	4
15. My tinnitus has made me feel distressed.	0	1	2	3	4
16. My tinnitus has made me feel frustrated with things.	0	1	2	3	4
17. My tinnitus has made me feel helpless.	0	1	2	3	4
18. My tinnitus has interfered with my ability to work.	0	1	2	3	4
19. My tinnitus has led me to despair.	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations.	0	1	2	3	4
21. My tinnitus has led me to avoid social situations.	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future.	0	1	2	3	4
23. My tinnitus has interfered with my sleep.	0	1	2	3	4
24. My tinnitus has led me to think about suicide.	0	1	2	3	4
25. My tinnitus has made me feel panicky.	0	1	2	3	4
26. My tinnitus has made me feel tormented.	0	1	2	3	4
Total					