Hearing Wellness Center
LET US HELP YOU HEARWELL™

Tinnitus History Questionnaire

Date Completed: _____

Name: _____ DOB: _____

General History

When was your last hearing exam? _____

Facility or provider's name? _____

What were the recommendations? _____

How long ago did you notice a change in your hearing?

☐ Within the past 90 days ☐ One to three years ☐ Four to six years ☐ Seven to 10 years ☐ 10+ years

Have you ever used assistive listening devices? _____

Do you suffer from acute or chronic dizziness? _____

Has anyone in your family had hearing loss? _____

Nature of the Tinnitus

Describe how your tinnitus sounds: _____

Where do you hear your tinnitus? ☐ Left Worse Than Right ☐ Right Worse Than Left
☐ Left = Right ☐ Central

My tinnitus is: ☐ Constant ☐ Intermittent

Does your 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 be the cause of your tinnitus? _____

Whom 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 explain: _____

How successful did you find these treatments? _____

Cloquet, MN
417 Skyline Blvd.
Cloquet, MN 55720
218-499-6241

Duluth, MN
1525 London Rd.
Duluth, MN 55812
218-623-1045

Bemidji, MN
677 Anne St. NW, Suite G
Bemidji, MN 56601
218-333-8833

Hermantown, MN
4163 Haines Rd.
Hermantown, MN 55811
218-623-6670

Superior, WI
1707 N 8th St., Suite 1
Superior, WI 54880
715-718-3355

Hearing Risk Assessment

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

Have you ever:

Been exposed to gunfire or an 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 concussions? ☐ Yes ☐ No

Had any operations involving your ear(s) or head? ☐ Yes ☐ No

Taken any of the following medications? ☐ Yes ☐ No

Quinine, Quinidine, Streptomycin, Kanamycin, Dihydrostreptomycin, Neomycin

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

Do you:

Have loose dentures, jaw pain or grinding and/or clicking sensations in your jaw? ☐ Yes ☐ No

Regularly take aspirin? ☐ Yes ☐ No

How much? _____

Find that 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

	Always	Sometimes	Never
Is it difficult for you to converse on the telephone?	A	S	N
Do others complain that you turn up the TV or radio too loud?	A	S	N
Do you have difficulty following conversations in a restaurant?	A	S	N
Does your hearing impact 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're in 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're 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
Do you dislike certain external sounds?	A	S	N
Do you wear ear protection/earplugs 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 were you aware of your tinnitus while you were awake? _____ %

(e.g., 100% aware: all the time, 25% aware: 1/4 of the time)

What percentage of the time was it disturbing? _____ %

Does your tinnitus prevent you from getting to sleep at night? ☐ Yes ☐ No

How has tinnitus affected your work life? _____

How has tinnitus affected your home life? _____

How has tinnitus affected your social activities? _____

General Health

If you answer 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: _____

Do you have any allergies to any medications, plastics, etc.? ☐ Yes ☐ No

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

Please list: _____

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 (black/green) ☐ Other: _____

How much artificial sweetener do you consume daily?

_____ oz. Diet Soda _____ oz. Sugar-Free Products

Which sweeteners do you use?

☐ Splenda® ☐ Agave ☐ Sugar ☐ Maple Syrup

☐ NutraSweet® ☐ Stevia ☐ Sweet'N Low® ☐ Honey

Do you drink alcohol? ☐ Yes ☐ No

Number of drinks/week: _____

Do you use tobacco? ☐ Yes ☐ No

Amount/day: _____

How long have you used tobacco? _____

If you quit, when? _____

Do you use recreational drugs? ☐ Yes ☐ No

Please explain: _____

Do you have any mental health diagnoses? ☐ Yes ☐ No

☐ Depression ☐ Anxiety ☐ Personality Disorder

☐ Eating Disorder ☐ OCD ☐ ADHD/ADD

☐ Other: _____

Does your medical history include any of the following?

☐ Diabetes ☐ Radiation Therapy to a Local Area ☐ Compromised Immune System

☐ TMJ ☐ Chemotherapy within Six Months ☐ Cognitive Ability

Have you ever had ear surgery? ☐ Yes ☐ No

Please explain: _____

Please list all major surgeries and illnesses in the past 10 years: _____

Do you have regular MRIs? ☐ Yes ☐ No

Please explain: _____

Sleep

When do you go to bed? _____a.m./p.m. Workdays _____a.m./p.m. 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? _____a.m./p.m. Workdays _____a.m./p.m. Weekends

Do you need an alarm to wake you? _____

When do you get up in the morning? _____a.m./p.m. Workdays _____a.m./p.m. 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

How 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 (due to death/divorce/illness/other)? _____

_____

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

Is it comfortable? _____

Is your bedroom: ☐ Cool ☐ Quiet ☐ Dark ☐ White Noise:

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

☐ Watch TV ☐ Read ☐ Eat ☐ Do Paperwork

☐ Exercise ☐ Use Cellphone ☐ 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 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: _____

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

_____

Medical Contact Details

Name and Address of GP: _____

Name and Address of ENT: _____

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

Signature _____ Date _____

TINNITUS FUNCTIONAL INDEX

Today's Date: _____ Your Name: _____
Month/Day/Year *Please Print*

Please read each question below carefully. To answer a question, select ONE of the numbers listed for that question, and draw a CIRCLE around it like this: (10%) or (1.)

I* | *Over the PAST WEEK:

What percentage of your time awake were you consciously AWARE OF your tinnitus?
Never aware ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◄ ***Always aware***

How STRONG or LOUD was your tinnitus?
Not at all strong or loud ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Extremely strong or loud***

What percentage of your time awake were you ANNOYED by your tinnitus?
None of the time ► 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100% ◄ ***All of the time***

SC* | *Over the PAST WEEK:

Did you feel IN CONTROL in regard to your tinnitus?
Very much in control ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Never in control***

How easy was it for you to COPE with your tinnitus?
Very easy to cope ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Impossible to cope***

How easy was it for you to IGNORE your tinnitus?
Very easy to ignore ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Impossible to ignore***

C Over the PAST WEEK:

How did tinnitus affect your ability to CONCENTRATE?
Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Completely interfered***

How did tinnitus affect your ability to THINK CLEARLY?
Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Completely interfered***

How did tinnitus affect your ability to FOCUS ATTENTION on other things besides your tinnitus?
Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Completely interfered***

SL* | *Over the PAST WEEK:

How often did your tinnitus make it difficult to FALL ASLEEP or STAY ASLEEP?
Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Always had difficulty***

How often did your tinnitus cause you difficulty in getting AS MUCH SLEEP as you needed?
Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***Always had difficulty***

How much of the time did your tinnitus keep you from SLEEPING as DEEPLY or as PEACEFULLY as you would have liked?
None of the time ► 0 1 2 3 4 5 6 7 8 9 10 ◄ ***All of the time***

A. Over the PAST WEEK, how much has your tinnitus interfered with:

	▼ Did not interfere									Completely interfered ▼
Your ability to HEAR CLEARLY?	0	1	2	3	4	5	6	7	8	9	10
Your ability to UNDERSTAND PEOPLE who are talking?	0	1	2	3	4	5	6	7	8	9	10
Your ability to FOLLOW CONVERSATIONS in a group or at meetings?	0	1	2	3	4	5	6	7	8	9	10

R. Over the PAST WEEK, how much has your tinnitus interfered with:

	▼ Did not interfere									Completely interfered ▼
Your QUIET RESTING ACTIVITIES?	0	1	2	3	4	5	6	7	8	9	10
Your ability to RELAX?	0	1	2	3	4	5	6	7	8	9	10
Your ability to enjoy PEACE AND QUIET?	0	1	2	3	4	5	6	7	8	9	10

Q. Over the PAST WEEK, how much has your tinnitus interfered with:

	▼ Did not interfere									Completely interfered ▼
Your enjoyment of SOCIAL ACTIVITIES?	0	1	2	3	4	5	6	7	8	9	10
Your ENJOYMENT OF LIFE?	0	1	2	3	4	5	6	7	8	9	10
Your RELATIONSHIPS with family, friends and other people?	0	1	2	3	4	5	6	7	8	9	10

How often did your tinnitus cause you to have difficulty performing your WORK OR OTHER TASKS, such as home maintenance, school work or caring for children or others?

Never had difficulty ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Always had difficulty*

E Over the PAST WEEK:

How ANXIOUS or WORRIED has your tinnitus made you feel?

Not at all anxious or worried ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely anxious or worried*

How BOTHERED or UPSET have you been because of your tinnitus?

Not at all bothered or upset ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely bothered or upset*

How DEPRESSED were you because of your tinnitus?

Not at all depressed ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Extremely depressed*

 08.15.08