Tinnitus
Treatment Center

HEALTHY HEARING FOR LIFE

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, thinnners or alcohol based cleaners?	[ ] Yes	[ ] No

Do you?

Have loose dentures, jaw pain or grinding and clicking sensations in the jaw	[ ] Yes	[ ] No
Regularly take asprin?	[ ] 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

	Always	Sometimes	Never
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

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: _____

_____

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 sweetners do you consume daily?

[ ] Diet soda [ ] Sugar-free products

Which sweetners 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

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: _____

_____

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					