Hearing Wellness Center

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

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

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 tinnitus fluctuate in intesity? ☐ 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 distrubing?_____

_____

Under what circumstances did the tinnitus start?_____

_____

What do you consider to be the cause of your 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 explain*

*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 - eg. music concert or clubs ☐ Yes ☐ No

_____

Had any noisy jobs ☐ Yes ☐ No

_____

Have 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, Quindidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin

_____

Used solvents, thinner, or alcohol based cleaner? ☐ Yes ☐ No

_____

Do you?

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

Regularly take asprin? ☐ Yes ☐ No

How much?_____

Do you find exposure to moderately loud sounds make 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 conversation 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/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? _____%
(eg. 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 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 sweetners do you consume daily?

_____ oz. Diet Soda _____oz. Sugar-free products

Which sweetners do you use?

☐ Splenda ☐ Agave ☐ Sugar ☐ Maple Syrup

☐ Nutrasweet ☐ Stevia ☐ Sweet n Low ☐ Honey

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 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 local area ☐ Compromised immune system

☐ TMJ ☐ Chemotherapy within 6 months ☐ Cognitive ability

Have you ever have ear surgery? ☐ Yes ☐ No

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?_____mins. / hrs.

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? (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 Treatment Center

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 that is listed for that question, and draw a *CIRCLE* around it like this: (10%) or (1).

I — Over the PAST WEEK...

1. 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*

2. 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*

3. 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...

4. 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*

5. 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*

6. 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...

7. Your ability to **CONCENTRATE**?

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Completely interfered*

8. Your ability to **THINK CLEARLY?**

Did not interfere ► 0 1 2 3 4 5 6 7 8 9 10 ◄ *Completely interfered*

9. 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...

10. 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*

11. 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*

12. 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*

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

	Over the PAST WEEK, how much has your tinnitus interfered with...	*Did not interfere*										*Completely interfered*
A	13. Your ability to **HEAR CLEARLY**?	0	1	2	3	4	5	6	7	8	9	10
	14. Your ability to **UNDERSTAND PEOPLE** who are talking?	0	1	2	3	4	5	6	7	8	9	10
	15. 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*
	16. Your **QUIET RESTING ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
	17. Your ability to **RELAX**?	0	1	2	3	4	5	6	7	8	9	10
	18. 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*
	19. Your enjoyment of **SOCIAL ACTIVITIES**?	0	1	2	3	4	5	6	7	8	9	10
	20. Your **ENJOYMENT OF LIFE**?	0	1	2	3	4	5	6	7	8	9	10
	21. Your **RELATIONSHIPS** with family, friends and other people?	0	1	2	3	4	5	6	7	8	9	10

22. 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...

23. 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*

24. 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*

25. 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*

Tinnitus Treatment Center