



Tinnitus History Questionnaire

Name: _____

Date: _____

Nature of your Tinnitus

How does your tinnitus sound? _____

Usual site of your tinnitus?

Left =Right	Left worse than Right	Right worse than Left	Central
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(Please circle the correct site)

Is your tinnitus constant or intermittent?	
Does your tinnitus fluctuate in intensity or loudness?	
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 your tinnitus start?	
What do you consider to have started 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?	<input type="checkbox"/> None <input type="checkbox"/> TRT <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Counseling <input type="checkbox"/> Masker <input type="checkbox"/> Music Therapy <input type="checkbox"/> Other please comment
How successful did you find these treatments?	

Have you ever:		Details/Comments
Been exposed to gunfire or explosion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Attended loud events (e.g. music concerts or clubs)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had any noisy jobs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had any noisy hobbies or home activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had any head injuries or concussion?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Had any operations involving your ear or head?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Taken any of the following medications: <i>Quinine, Quindidine, Streptomycin, Kanamycin, Dihydrostreptomycin, Neomycin</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Used solvents, thinners, or alcohol based cleaners?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you		
Have loose dentures, jaw pain or grinding or clicking sensation in the jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Regularly take aspirin or dispirin?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Have any feelings of ear pressure or blockage?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you find exposure to moderately loud sounds make your tinnitus worse?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
General Hearing Problems		
Do you have any difficulties hearing when there is background noise?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have difficulties understanding in one-to-one conversations?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have difficulties hearing the TV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have difficulties hearing on the telephone?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you have any dizziness or balance problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you find external sounds unpleasant or uncomfortable?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you dislike certain external sounds?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you wear ear protection/ear plugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

Please rank the auditory problems you experience: Most troublesome (1) to least troublesome (3)

_____ Hearing _____ Tinnitus _____ Sensitivity to loud sounds

Affect of your Tinnitus

Details/Comments

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)	%	
What percentage of the time was it disturbing	%	
Does your tinnitus prevent you from getting to sleep at night?	<input type="checkbox"/> Yes <input type="checkbox"/> No	
How many times per night did you awake in the last week?		
How has tinnitus affected your work life?		
How has tinnitus affected your home life?		
How has tinnitus affected your social activities?		

General Health

Details/Comments

What is your general health like?	
Are you taking any medications? If yes, please specify	

Compensation

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

Medical Contact Details:

Name and address/clinic of your GP: _____

Name and address/clinic of your ENT: _____

I give consent to release results to my GP and /or ENT: Yes No _____

Sign

Date

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