

# Tinnitus History Questionnaire

Name:

Date Completed:

DOB:

## Nature of the Tinnitus

How does the tinnitus sound? \_\_\_\_\_  
\_\_\_\_\_

Usual site of the tinnitus?  
(Please circle the correct site)

Left=Right

Left worse  
than Right

Right worse  
than Left

Central

Is the tinnitus constant or  
intermittent? \_\_\_\_\_

Does the tinnitus fluctuate in  
intensity? \_\_\_\_\_

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 comment \_\_\_\_\_  
\_\_\_\_\_

How successful did you find these treatments? \_\_\_\_\_

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Date Completed \_\_\_\_\_

*Have you ever:*

- Been exposed to gunfire or explosion?
- Attended loud events (e.g. music concerts or clubs?)
- Had any noisy jobs?
- Had any noisy hobbies or home activities?
- Had any head injuries or concussion?
- Had any operations involving your ear or head?
- Taken any of the following:  
 Quinine, Quindidine, Streptomycin,  
 Kantamycin, Dihydrostreptomycin, Neomycin
- Used solvents, thinners or alcohol based cleaners?

**Y/N      Details/Comments**

<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

*Do you:*

- Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?
- Regularly take aspirin or dispirin?
- Have any feelings of ear pressure or blockage?
- Do you find exposure to moderately loud sounds make your tinnitus worse?
- What is your current occupation?

**Y/N      Details/Comments**

<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

## General Hearing Problems

- Do you have any difficulties hearing when there is background noise?
- Do you have difficulties understanding in one-to-one conversations?
- Do you have difficulties hearing the TV?
- Do you have difficulties hearing on the telephone?
- Do you have any dizziness or balance problems?
- Do you find external sounds unpleasant or uncomfortable?
- Do you dislike certain external sounds?
- Do you wear ear protection/ear plugs?

**Y/N      Details/Comments**

<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	
<input type="checkbox"/>	

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

\_\_\_\_\_ Hearing Loss      \_\_\_\_\_ Tinnitus      \_\_\_\_\_ Sensitivity to Loud Sounds

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## Effect of the 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 or the time)?

-What percentage of the time was it disturbing?

-Does your tinnitus prevent you from getting to sleep at night? Y/N

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

-How has tinnitus affected your work life?


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-How has tinnitus affected your home life?

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-How has tinnitus affected your social activities?

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## General Health

What is your general health like?

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Are you taking any medications? (If yes, please specify)

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## 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?

Y/N

## Medical Contact Details

Name and Address of GP

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Name and Address of ENT

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I give consent to release results to my GP/ENT

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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