Tinnitus History Questionnaire

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 with the response that best reflects how your tinnitus has affected you.

Name:	Date:

Nature of the Tinnitus

How does the tinnitus sound?				
Usual site of the tinnitus?	Left + Right ○	Left worse than Right ○	Right worse than Left ○	Central ○
Is the tinnitus constant or intermittent?				
Does the 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 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? Please tick box

☐ None ☐ Hearing Aid ☐ Masker ☐ TRT ☐ Counselling ☐ Music Therapy

Other - please provide more detail _____

_____

How successful did you find these treatments?

_____

_____

_____

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Tinnitus History Questionnaire

Have you ever:	Y/N	Details/Comments
Been exposed to gunfire or explosion? • How often were you exposed? • Did you wear hearing protection?	Yes ◯ No ◯	
Attended loud events? (e.g. concerts, 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 or head?	Yes ◯ No ◯	
Used solvents, thinners or alcohol based cleaners?	Yes ◯ No ◯	
Taken any of the following medications: • Quinine, Quinidine, Streptomycin, Kanamycin, Dihydristreptomycin, Neomycin	Yes ◯ No ◯	

Do you:	Y/N	Details/Comments
Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?	Yes ◯ No ◯	
Regularly take aspirin or dispirin?	Yes ◯ No ◯	
Have any feelings of ear pressure or blockage?	Yes ◯ No ◯	
Do you find exposure to moderately loud sounds make your tinnitus worse?	Yes ◯ No ◯	
What is your current occupation?	Yes ◯ No ◯	

General Hearing Problems	Y/N	Details/Comments
Do you have any difficulties hearing when there is background noise?	Yes ◯ No ◯	
Do you have difficulties understanding in one-to-one conversations?	Yes ◯ No ◯	
Do you have difficulties hearing the TV?	Yes ◯ No ◯	
Do you have difficulties hearing on the telephone?	Yes ◯ No ◯	
Do you have any dizziness or balance problems?	Yes ◯ No ◯	
Do you find external sounds unpleasant or uncomfortable?	Yes ◯ No ◯	
Do you dislike certain external sounds?	Yes ◯ No ◯	
Do you wear ear protection / ear plugs?	Yes ◯ No ◯	

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Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3)	Select one	Hearing Loss
	Select one	Tinnitus
	Select one	Sensitivity to Loud Sounds

Effect of the Tinnitus	Y/N	Details/Comments
Does your tinnitus prevent you from getting to sleep at night?	Yes ◯ No ◯	
How many times per night did you awake in the last week?	Yes ◯ No ◯	
How has tinnitus affected your work life?	Yes ◯ No ◯	
How has tinnitus affected your home life?	Yes ◯ No ◯	
How has tinnitus affected your social activities?	Yes ◯ No ◯	

General Health

What is your general health like?

Are you taking any medications? Yes ◯ No ◯

If yes, please specify.

Compensation	Y/N	Details/Comments
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 ◯	

Medical Contact Details

Name and Address of GP

Name and Address of ENT

I give consent to release results to my GP /ENT Signed:

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

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