Tinnitus History Questionnaire

Name: DOB: Date Completed:

Nature of the Tinnitus

How does the tinnitus sound?

Usual site of the tinnitus? (Please check 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 ☐ Counselling ☐ Music Therapy
☐ Other - please comment

How successful did you find these treatments?

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Tinnitus History Questionnaire (cont.)

Name: DOB: Date Completed:

Have you ever?	Y/N	Details/Comments
Been exposed to gunfire or explosion	☐ Y ☐ N	
Attended loud events e.g. music concerts or clubs	☐ Y ☐ N	
Had any noisy jobs	☐ Y ☐ N	
Had any noisy hobbies or home activities	☐ Y ☐ N	
Had any head injuries or concussion	☐ Y ☐ N	
Had any operations involving your ear or head	☐ Y ☐ N	
Taken any of the following medications: Quinine, Quindidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin Used solvents, thinners or alcohol based cleaners?	☐ Y ☐ N	

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

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

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

Hearing Loss	Tinnitus	Sensitivity to Loud Sounds

Tinnitus History Questionnaire (cont.)

Name: DOB: Date Completed:

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% aware¼ 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?

How has tinnitus affected your home life?

How has tinnitus affected your social activities?

General Health

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, OVA, motor vehicle accident claim or any other legal action in relation to your tinnitus?

☐ Y ☐ N

Medical Contact Details

Name and Address of GP

Name and Address of ENT

I give consent to release 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?