NAME: ______________________________ DATE COMPLETED: ___________

Nature of the Tinnitus

What does the tinnitus sound like?

____

Usual site of the tinnitus:

❑ Left ❑ Right ❑ Left worse than Right ❑ Right worse than Left ❑ Left=Right ❑ Central

Is the tinnitus: ❑ constant ❑ intermittent

Does the tinnitus fluctuate in intensity? ❑ Yes ❑ No

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?

____

Can you remember an event that triggered your tinnitus?

____

Who have you consulted about your tinnitus?

____

____

Has a cause for your tinnitus ever been diagnosed?

____

____

What treatments have you tried for your tinnitus?

❑ None ❑ Hearing Aid ❑ Masker ❑ TRT ❑ Counseling ❑ Music Therapy

❑ Other: ________________________

How successful did you find these treatments?

____

____

Have you ever:

Been exposed to gunfire or explosion? ❑ No ❑ Yes Explain: ______________________________

Attended loud events (music concerts, etc.)? ❑ No ❑ Yes Explain: ________________________

Had any noisy jobs? ❑ No ❑ Yes Explain: ______________________________

Had any noisy hobbies or activities? ❑ No ❑ Yes Explain: ______________________________

Had any head injuries or concussions? ❑ No ❑ Yes Explain: ______________________________

Had any operations involving your ear or head? ❑ No ❑ Yes Explain: ______________________

Taken any of the following medications? ❑ Quinine ❑ Streptomycin ❑ Kantamycin
❑ Dihydrostreptomycin ❑ Neomycin

Used solvents, thinners, or alcohol-based cleaners?
❑ No ❑ Yes Explain: ______________________________

Do you:

Have loose dentures, jaw pain, or grinding and clicking sensations in the jaw?
❑ No ❑ Yes Explain: ______________________________

Regularly take aspirin? ❑ No ❑ Yes Explain: ______________________________

Have any feelings of ear pressure or blockage:
❑ No ❑ Yes Explain: ______________________________

Does exposure to moderately loud sounds make your tinnitus worse?
❑ No ❑ Yes Explain: ______________________________

What is your current occupation? ____

General Hearing Problems

Do you have difficulties hearing when there is background noise?
❑ No ❑ Yes Explain: ______________________________

Do you have difficulties understanding in one-to-one conversations?
❑ No ❑ Yes Explain: ______________________________

Do you have difficulties hearing the TV?
❑ No ❑ Yes Explain: ______________________________

Do you have difficulties hearing on the telephone?
❑ No ❑ Yes Explain: ______________________________

Do you have any dizziness or balance problems?
❑ No ❑ Yes Explain: ______________________________

Do you find external sounds unpleasant or uncomfortable?
❑ No ❑ Yes Explain: ______________________________

Do you dislike certain external sounds?
❑ No ❑ Yes Explain: ______________________________

Do you wear ear protection/ear plugs?

❑ No ❑ Yes Explain: ___________________________________

Please rank the auditory problems you experience from 1-3, with "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?

________%

What percentage of the time was it disturbing? ________%

Does your tinnitus prevent you from getting to sleep at night? ❑ No ❑ Yes

How many times per night did your tinnitus wake you in the last week? ________

How has tinnitus affected your work life?

____

____

How has tinnitus affected your home life?

____

____

How has tinnitus affected you social activities?

____

____

General Health

How is your general health?

____

____

Are you taking any medications? ❑ No ❑ Yes List: ____

Compensation

Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claim, or any legal action in relation to your tinnitus?

❑ No ❑ Yes Explain: ____

Medical Contact Details

Name & address of General Practitioner:

____

____

Name & address of ENT:

____

____

I give my consent to release results of any testing done by Hearing Healthcare Center to my GP and/or ENT.

Signed: ____ Date: ____________________

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

____

____

____

____

____

____