TPA Tinnitus Practitioners Association

Initial Tinnitus Questionnaire

Patient Name: _____ **Date:** _____

Reason for today's appointment: _____

Allergies to any medications, plastics, etc.? _____

Current medications: _____

_____

Ear Health History

Have you been exposed to loud sounds/noise? ☐Yes ☐No If yes, explain_____

Have you ever had ear surgery? ☐Yes ☐No If yes, ear? ☐Right ☐Left type?_____

Have you ever had any head/ear trauma? ☐Yes ☐No If yes, explain_____

Have you ever taken medication that had a toxic effect on your hearing? ☐Yes ☐No If yes, type?_____

*Have you experienced any drainage from your ear(s) within the last 90 days? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

*Do you suffer from pain or discomfort in your ear(s)? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have temporomandibular joint (TMJ) disorder? ☐Yes ☐No

If yes, ☐Right ☐Left ☐Both

Do you have a congenital or traumatic deformity of the ear? ☐Yes ☐No

If yes, describe: _____

Do you often have significant cerumen (earwax) accumulation in your ear canal?

☐Right ☐Left ☐Both ☐Neither

*Do you suffer from acute or chronic dizziness? ☐Yes ☐No

Please list all major surgeries (Past 10 years:

_____

_____

_____

Please list any serious illnesses (Past 10 years):

_____

_____

_____

Are you diabetic? ☐Yes ☐No

Do you have high blood pressure? ☐Yes ☐No

Initial Tinnitus Questionnaire

Tinnitus

Tinnitus refers to any kind of sound in your head…ringing, hissing and so on. Think only about your tinnitus in regard to the following questions……..

How does the tinnitus sound?_____ Constant? Intermittent?

In which ear is your tinnitus? ☐Right ☐Left ☐Both ☐Head ☐Other

How long ago did you notice the tinnitus? ☐Recently ☐1-3 years ☐3-10 years ☐More than 10 years

Do you remember the onset of your tinnitus? ☐Yes ☐No

Was it a sudden or progressive onset? ☐Sudden ☐Progressive

Was it related to any other medical or environmental condition? ☐Yes ☐No

*Does your tinnitus pulse with your heartbeat? ☐Yes ☐No

*Is your tinnitus triggered by head or neck movement? ☐Yes ☐No

Is there any one in your family who has/had tinnitus? ☐Yes ☐No

Have you consulted any other professional or tried any treatment for your tinnitus? ☐Yes ☐No

If yes, explain_____

Does your tinnitus….

Make it difficult to fall asleep?	always	sometimes	never
Make it difficult to concentrate while reading?	always	sometimes	never
Make it difficult to relax in a quiet room?	always	sometimes	never
Make it difficult to focus your attention away from your tinnitus?	always	sometimes	never
Cause you to feel angry?	always	sometimes	never
Cause you to feel stressed?	always	sometimes	never
Cause you to feel sad?	always	sometimes	never

Office Use Only (2)___ (1)___ (0)___ Total_____

Sound Tolerance

Sound tolerance refers to how you react to sounds in your environment. Think only about your sound tolerance in regard to the following questions…..

Do you use ear protection (earplugs or earmuffs) specifically for tinnitus? ☐Yes ☐No

Do you have a decreased tolerance to sound (are sounds bothersome to you when they seem normal to other people around you)? ☐Yes ☐No

Does sound in your environment….

Cause an increase in your tinnitus?	always	sometimes	never
Cause you to avoid going certain places?	always	sometimes	never
Cause you to feel irritated?	always	sometimes	never

Initial Tinnitus Questionnaire

Hearing

Hearing refers to your ability to detect sounds in your environment or your ability to understand the speech of other. Think only about your hearing in regard to the following questions…

When was your last hearing exam? _____ By whom? _____

What were the results? _____Recommendations?_____

Have you ever worn hearing aids? ☐Yes ☐No

*Have you experienced a sudden hearing loss? ☐Yes ☐No

Does your hearing….

Limit or hamper your personal or social life?	always	sometimes	never
Cause you to hear people but not understand what they are saying?	always	sometimes	never

What do you consider is your main problem? Hearing ☐ Tinnitus ☐ Sound tolerance ☐

If you answered ***"tinnitus" as your main problem…***

What percent of the time are you aware of it? _____

How *strong*, or *loud* was your tinnitus, on average, over the last month? "0" would be "no tinnitus and "10" would be "as loud as you can imagine." (Severity)

1 2 3 4 5 6 7 8 9 10

How much has tinnitus *annoyed* you, on average, over the last month" "0" would be "not annoying at all" and "10" would be "as annoying as you could imagine." (Annoyance)

1 2 3 4 5 6 7 8 9 10

How much did tinnitus impact your life, over the last month? "0" would be "not at all"; "10" would be "as much as you could imagine." (Effect)

1 2 3 4 5 6 7 8 9 10

Have you experienced any stressful events within the last 12 months?

_____

_____

_____

Additional Information:

_____

_____

_____

_____

_____