

# Tinnitus History Questionnaire

Name:

DOB:

Date Completed:

## 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

Counselling

Music Therapy

Other - please comment

How successful did you find  
these treatments?

---

# Tinnitus History Questionnaire

Name

DOB

Date Completed

Have you ever?

Y/N

Details/Comments

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 medications:

Quinine, Quindidine, Streptomycin,

Kantamycin, Dihydrostreptomycin, Neomycin

Used solvents, thinners or alcohol based cleaners?

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?

## General Hearing Problems

Y/N

Details/Comments

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?

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

Name

DOB

Date Completed

## Effect of the Tinnitus

- 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?

## Details/Comments

%	
%	

- 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, 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

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?