Initial Tinnitus Questionnaire

Patient Name: _____ **Date**: _____
Reason for today's appointment: _____
Allergies to any medications, plastics, etc. : _____
Place of employment: _____
What do you do: _____
Hobbies, interests: _____

EAR HEALTH HISTORY

Have you been exposed to loud sounds/noise? ☐ Yes ☐ No What loud noises? _____
Have you ever had ear surgery? ☐ Yes ☐ No
What was the surgery? _____
Have you ever had any head/ear trauma? ☐ Yes ☐ No What was the trauma? _____
_____

Have you ever taken medication that had a toxic effect on your hearing? ☐ Yes ☐ No
What was the toxic medication? _____
*Have you experienced any drainage from your ears within the last 90 days? ☐ Yes ☐ No
Which ear did you have drainage? ☐ Right ☐ Left
*Do you suffer from pain or discomfit in your ears? ☐ Yes ☐ No ☐ Right ☐ Left
Do you have temporomandibular joint (TMJ) disorder? ☐ Yes ☐ No ☐ Right ☐ Left
Do you have a congenital or traumatic deformity of the ear? ☐ Yes ☐ No Please explain:
_____
_____

Do you have significant cerumen (earwax) accumulation in your ear canal? ☐ Yes ☐ No ☐ Right ☐ Left
*Do you suffer from acute or chronic dizziness? ☐ Yes ☐ No

Please list all major surgeries in the past 10 years: _____
_____
_____

Please list any serious illnesses in the past 10 years: _____
_____
_____
Are you diabetic? ☐ Yes ☐ No Do you have a pacemaker? ☐ Yes ☐ No
Do you have high blood pressure? ☐ Yes ☐ No Is it controlled by medication? ☐ Yes ☐ No
Do you smoke? ☐Yes ☐No; Have you ever smoked? ☐Yes ☐No; How long? _____
How many packs a day? _____

TINNITUS

Tinnitus refers to any kind of sound in your head…ringing, hissing, buzzing, crickets, music, etc. Please think about your tinnitus in regard to the following questions.

When did you first notice your tinnitus? _____What were you doing? _____
What do you think caused the tinnitus? _____
Please describe the sounds you perceive as tinnitus? _____
Has the tinnitus changed since you first noticed it? _____
Where does it sound like your tinnitus is? ☐Right ear ☐Left ear ☐Both ears ☐Head ☐Other
Was the onset sudden or progressive? _____
Was the onset related to any other medical or environmental condition? _____
*Does your tinnitus pulse with your heartbeat? ☐Yes ☐No
*Do you have headaches? ☐Yes ☐No
*Do you have blurry vision? ☐Yes ☐No
* Do you have nausea or vomiting? ☐Yes ☐No
*Is your tinnitus triggered by head or neck movement? ☐Yes ☐No
Have you consulted any other professional for your tinnitus? ☐Yes ☐No
Who have your consulted? (ENT, family physician, etc.) _____
What have you tried? (medication, hearing aid, masking, diet, etc.) _____
_____
_____

What percentage of the time are you aware of tinnitus? _____
What percentage of the time are you annoyed by tinnitus? _____

On average, on a scale of 0 – 10, how loud has your tinnitus been over the last month?
0 1 2 3 4 5 6 7 8 9 10

On average, on a scale of 0 – 10, how annoyed have you been by your tinnitus on average over the last month?
0 1 2 3 4 5 6 7 8 9 10

On a scale of 0 – 10, how much did tinnitus impact or effect your life on average over the last month?
0 1 2 3 4 5 6 7 8 9 10

SOUND TOLERANCE

Sound tolerance refers to how you react to sound in your environment. Think only about your tolerance for sound in regards to the following questions.

Do you use ear protection? ☐Yes ☐No In what situations do you wear ear protection? _____
Do you have a decrease tolerance to sound (are sounds bothersome to you when they seem normal to other people around you)? ☐Yes ☐No
Please list sounds which bother you. _____
_____
_____
Does sound in your environment increase your tinnitus? ☐Yes ☐No
Do you avoid certain places because of sound tolerance? ☐Yes ☐No
What types of situations do you avoid because of sound tolerance? _____

HEARING

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

When was your last hearing test? _____
Where did you have your hearing tested?_____
Was your hearing normal? ☐Yes ☐No
Have hearing aids ever been recommended? ☐Yes ☐No
Have you ever worn hearing aids? ☐Yes ☐No
*Have you ever experienced sudden hearing loss? ☐Yes ☐No
Does your hearing limit or hamper your personal or social life? ☐Yes ☐No
Do you sometimes misunderstand what people are saying? ☐Yes ☐No

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

Have you experienced any stressful life events within the last 12 months? Please list them. _____
_____
_____

How would your life be different without tinnitus, hearing loss or sound tolerance issues? _____
_____
_____

What are your goals in regards to tinnitus, hearing loss or sound tolerance issues? _____
_____
_____

Current medications: Please use an additional page if necessary

NAME OF DRUG	DOSE	HOW OFTEN (ex. once per day)	ROUTE (example orally)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			