

Tinnitus History Questionnaire	Name: <input type="text"/>
	DOB: <input type="text"/> Date: <input type="text"/>
<u>Nature of the Tinnitus</u>	
How Does the Tinnitus Sound?	<input type="text"/>
Usual site of the tinnitus? (check box)	<input type="checkbox"/> Left=Right <input type="checkbox"/> Left > right <input type="checkbox"/> Right > Left <input type="checkbox"/> Central
Is the tinnitus constant or intermittent?	<input type="text"/>
Does the tinnitus fluctuate in intensity or loudness?	<input type="text"/>
What makes your tinnitus worse?	<input type="text"/>
What makes your tinnitus better?	<input type="text"/>
<u>Tinnitus History</u>	
When did you first become aware of your tinnitus?	<input type="text"/>
When did your tinnitus first become disturbing?	<input type="text"/>
Under what circumstances did the tinnitus start?	<input type="text"/>
What do you consider to have started the tinnitus?	<input type="text"/>
Who have you consulted about your tinnitus?	<input type="text"/>
What have previous professionals said your tinnitus is due to?	<input type="text"/>

<u>What treatments have you tried for your tinnitus (check all that apply)?</u>		
<input type="checkbox"/> None	<input type="checkbox"/> Hearing Aid	<input type="checkbox"/> Masker
<input type="checkbox"/> TRT	<input type="checkbox"/> Counseling	<input type="checkbox"/> Music Therapy
Other – Please Comment: <input type="text"/>		

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How Successful Did You Find the Treatments You Used in the Past?		
<input type="text"/>		
Have You Ever?:	Y/N	Details/Comments
Been exposed to gunfire or explosion? How often were you exposed? Did you wear hearing protection?	<input type="checkbox"/>	<input type="text"/>
Attended loud events? (e.g., concerts, clubs)	<input type="checkbox"/>	<input type="text"/>
Had any noisy jobs?	<input type="checkbox"/>	<input type="text"/>
Had any noisy hobbies or home activities?	<input type="checkbox"/>	<input type="text"/>
Had any head injuries or concussion?	<input type="checkbox"/>	<input type="text"/>
Had any operations involving your ear or head?	<input type="checkbox"/>	<input type="text"/>
Used solvents, thinners or alcohol based cleaners?	<input type="checkbox"/>	<input type="text"/>
Taken any of the following medications: Quinine, Quinidine, Streptomycin, Kanamycin, Dihydrostreptomycin, Neomycin	<input type="checkbox"/>	<input type="text"/>
Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?	<input type="checkbox"/>	<input type="text"/>
Regularly take aspirin or NSAIDs?	<input type="checkbox"/>	<input type="text"/>
Have any feelings of ear pressure or blockage?	<input type="checkbox"/>	<input type="text"/>
Do you find exposure to moderately loud sounds make your tinnitus worse?	<input type="checkbox"/>	<input type="text"/>
What is your current occupation?	<input type="checkbox"/>	<input type="text"/>

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

Please rank the auditory problems you experience, from most troublesome (1) to least troublesome (3).	<input type="checkbox"/>	Hearing Loss
	<input type="checkbox"/>	Tinnitus
	<input type="checkbox"/>	Sensitivity to Loud Sounds

Effect of the Tinnitus:	Y/N	Details/Comments
Does your tinnitus prevent you from getting to sleep at night?	<input type="checkbox"/>	<input type="text"/>
How many times per night did you awake in the last week?	<input type="checkbox"/>	<input type="text"/>
How has tinnitus affected your work life?	<input type="checkbox"/>	<input type="text"/>
How has tinnitus affected your home life?	<input type="checkbox"/>	<input type="text"/>
How has tinnitus affected your social activities?	<input type="checkbox"/>	<input type="text"/>

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<u>General Health</u>	Details/Comments
What is your general health like?	<input type="text"/>
Are you taking any medications? If yes, please list.	<input type="text"/>
<u>Compensation</u>	
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? If so, please explain.	<input type="text"/>

<u>Medical Contact Details</u>	
Name and Address of GP:	<input type="text"/>
Name and Address of ENT:	<input type="text"/>
I give consent to release results to my GP/ENT:	<input type="text"/>

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?
<input type="text"/>