AUDIOLOGY ASSOCIATES OF WESTCHESTER™

550 Mamaroneck Ave. 4th Fl. Suite 407
Harrison, NY 10528

325 NY-100
Somers, NY 10589

TINNITUS HISTORY QUESTIONNAIRE

Name: _____ **Date completed:** _____

DOB: _____

Nature of the Tinnitus

How does the tinnitus sound? _____

_____

Usual site of the tinnitus? **(circle correct site)** Left/Right ear | Left worse than right ear | 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? **(circle all that apply)**

None	Counseling	Other:_____
TRT	Masker	
Hearing Aid	Music Therapy	

How successful did you find these treatments?_____

Have you ever:

	Y/N	Details/Comments
Been exposed to gunfire or explosions?		
Attended loud events (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 or Neomycin?		
Used solvents, thinners or alcohol based cleaners?		

Do you

	Y/N	Details/Comments
Have loose dentures, jaw pain, or grinding and clicking sensations in the jaw?		
Regularly take aspirin or disprin?		
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

Effects of the Tinnitus

	%	Details/Comments
Over the past week, what percentage of the time that you were awake, were you aware of your tinnitus? (e.g. 100% aware all of the time, 25% aware ¼ of 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?_____
_____

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, disability, veterans, DVA, motor vehicle accident claim, or any other legal action in relation to your tinnitus? (Y/N)_____

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

Medical Contact Details

Internist
Name _____
Address _____
_____
Phone _____

ENT Physician
Name _____
Address _____
_____
Phone _____

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Tinnitus Reaction questionnaire (TRQ)

Name: _____ **Date Completed: _____**

This questionnaire is designed to find out what sort of effects tinnitus has had on your lifestyle, general well-being, etc. Some of the effects below may apply to you, some may not. Please answer **all** questions by circling the number that best reflects how your tinnitus has affected you **over the past week.**

	Not at all	A little of the time	Some of the time	A good deal of the time	Almost all of the time
1. My tinnitus has made me unhappy	0	1	2	3	4
2. My tinnitus has made me feel tense	0	1	2	3	4
3. My tinnitus has made me feel irritable	0	1	2	3	4
4. My tinnitus has made me feel angry	0	1	2	3	4
5. My tinnitus has led me to cry	0	1	2	3	4
6. My tinnitus has led me avoid quiet situations	0	1	2	3	4
7. My tinnitus has made me feel less interested in going out	0	1	2	3	4
8. My tinnitus has made me feel depressed	0	1	2	3	4
9. My tinnitus has made me feel annoyed	0	1	2	3	4
10. My tinnitus has made me feel confused	0	1	2	3	4
11. My tinnitus has “driven me crazy”	0	1	2	3	4
12. My tinnitus has interfered with my enjoyment of life	0	1	2	3	4
13. My tinnitus has made it hard for me to concentrate	0	1	2	3	4
14. My tinnitus has made it hard for me to relax	0	1	2	3	4
15. My tinnitus has made me feel distressed	0	1	2	3	4
16. My tinnitus has made me feel helpless	0	1	2	3	4
17. My tinnitus has made me feel frustrated with things	0	1	2	3	4
18. My tinnitus has interfered with my ability to work	0	1	2	3	4
19. My tinnitus has led me to despair	0	1	2	3	4
20. My tinnitus has led me to avoid noisy situations	0	1	2	3	4
21. My tinnitus has led me to avoid social situations	0	1	2	3	4
22. My tinnitus has made me feel hopeless about the future	0	1	2	3	4
23. My tinnitus has interfered with my sleep	0	1	2	3	4
24. My tinnitus has led me to think about suicide	0	1	2	3	4
25. My tinnitus has made me feel panicky	0	1	2	3	4
26. My tinnitus has made me feel tormented	0	1	2	3	4
Total					