Tinnitus History Questionnaire

COPPER SKY
HEARING & TINNITUS

Name: _____ Date: _____

Nature of the Tinnitus

How do you describe the sound of your tinnitus? _____

Where is the usual site of your tinnitus? **(circle one)** Left = Right | Left worse than Right | Right worse than Left | Central

Is the tinnitus constant or intermittent? _____

Does the tinnitus fluctuate in the 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 your tinnitus start? _____

What do you consider to have started your 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: _____

How successful did you find these treatments? _____

Have you ever?

	YES	NO
Been exposed to gunfire or explosion?	❑	❑
Attended loud events such as concerts or clubs?	❑	❑
Had any noise 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 ❑ Dihydrosteptomycin

❑ Neomycin ❑ Used solvents, thinners or alcohol-based cleaners? ❑ None of these

Do you?

	YES	NO
Have loose dentures or jaw pain?	❑	❑
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

	YES	NO
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 or ear plugs?	❑	❑

Which of these bothers you the most right now?

Please write:

1 = Bothers me the most 2 = Somewhat bothersome 3 = Least bothersome

____ Hearing Loss ____ Tinnitus ____ Sensitivity to Loud Sounds