Audiology Providers, P.C.

TINNITUS ASSESSMENT

Patient Name: _____ Age: _____ Date:____/____/_____

Address:_____ Phone: ( )_____

1.) I have had tinnitus in its present form for:
(circle the appropriate letter)

a. Less than a year
b. One to two years
c. Two to three years
d. Three to five years
e. Longer than five years

2.) Prior to my present form of tinnitus, I had a mild tinnitus for (length of time): _____

3.) My tinnitus seems to be primarily located in:
(circle the appropriate letter)

a. the left ear
b. the right ear
c. both ears equally
d. both ears but unequal
e. my head

4.) The severity of my tinnitus in its worse form, according to the scale below, is represented by the number: 1 2 3 4 5 6 7 8 9 10

Mild Moderately Extremely Severe Severe

5.) The loudeness of my tinnitus is:
(circle the appropriate letter)

a. Fairly constant from day to day
b. Fluctuates widely being very loud on some days and very mild on other days
c. Usually constant but on rare occasions will decrease markedly

6.) On the scale below, indicate the pitch of your tinnitus. It might help to imagine the scale as if it were a piano keyboard.

1 2 3 4 5 6 7 8 9 10

Low Pitch Middle Pitch High Pitch

7.) Check any items below which describe how your tinnitus sounds:
(circle the appropriate letter)

a. hissing f. ringing
b. cricket-like g. steam whistle
TINNITUS QUESTIONAIRE CONT'D:

c. pounding h. bells
d. pulsating I. clanging
e. whistle j. ocean roaring

8.) My tinnitus appears worse: (circle the appropriate letter)

a. When I am tired
b. When I am tense and nervous
c. When I am relaxed
d. After use of alcohol

9.) Do you smoke? Yes No

If so, for how long have you been a smoker? _____years
If so, how many cigarettes per day? _____

10.) Do you drink coffee? Yes No

If so, how many cups per day?_____

11.) Check any of the following items which give you any relief from your tinnitus.
(circle the appropriate letter)

a. Listening to radio or T.V.
b. Traffic sounds
c. Sounds of running water (e.g. shower)
d. Medication (_____kind)
e. Changes in altitude
f. Other_____

12.) Have you ever experienced a head injury? Yes No

If so, were you ever unconscious? Yes No
How long ago was the accident? _____ years

13.) Have you been exposed to loud sounds? Yes No

If yes, explain briefly: _____
_____

14.) Are you presently working in or exposed to loud sounds? Yes No

If yes, explain briefly: _____
_____

15.) Do you wear ear protection in the presence of loud sounds? Yes No