EAR INSTITUTE OF TEXAS, P.A.

Tinnitus Questionnaire

Tinnitus **is the medical term for ringing, roaring, or other noises that a person hears in the ear(s). When evaluating symptoms of tinnitus, patient history and description of the symptoms is extremely important in making a correct diagnosis. Please mark all answers that apply and fill in the appropriate blanks.**

YES NO

Location:

____ ____ The sound is heard in which ear?
___right ___left ___both

Quality:

Rate the severity of how the tinnitus is bothersome to your lifestyle on a scale of 1-10
Right___/10 Left___/10 **If you scored either of these as a "5" or above, please complete reverse side.**

____ ____ Does it affect your ability to sleep?
____ ____ Does it affect your ability to concentrate?

What best describes your tinnitus?
___Ringing
___Rushing, roaring, or seashell noise
___Buzzing
___Whistling
___Pulsatile: __regular with heartbeat __erratic rhythm
___Popping
___Other (please describe)_____

Frequency/Pitch
___High frequency
___Mid frequency
___Low frequency

Duration, timing, and context:

How long ago did you first begin experiencing tinnitus? _____
____ ____ Is the tinnitus constant?
____ ____ Is the tinnitus recurrent?
If recurrent, how long do episodes last? (provide range):_____ (circle one) seconds/minutes/days
How often do the episodes occur? (provide range) _____ per day/week/month

Modifying factors:

____ ____ Is the tinnitus triggered or made worse by:
____stress/anxiety ____loud noise ____dietary factors (i.e. caffeine or salt) ____positions
Other (please explain)_____?
____ ____ Is it more prominent in a quiet environment?
What makes the tinnitus less noticeable_____?
____ ____ Have you been exposed to loud noise? If so what: _____?
____ ____ Have you started new medications when the tinnitus began (especially intravenous antibiotics or chemotherapy)? If so what medication_____?

Associated signs and symptoms (check where appropriate):

___Headache ___Ear pain ___Dizziness ___Allergies ___Ear infections
___Visual changes ___Hearing loss ___Feeling of pressure in the ears
Other (please explain)_____

Previous evaluation and treatment:

____ ____ Have you seen a physician for the tinnitus? If so, name_____
What prior tests have you had: ____Hearing Test ____ABR ____MRI?
What prior treatments have you tried_____?

Patient Name_____ Patient Signature_____