TINNITUS ASSESSMENT

Today's Date: _____

Name: _____ DOB: ____/____/____

Reason for appointment today? _____

Medical History *(check any that apply)*

- ☐ Acute or chronic dizziness
- ☐ Dementia/Alzheimer's
- ☐ Impaired cognitive ability
- ☐ Poor vision
- ☐ Trauma to head/neck
- ☐ Implantable medical device (i.e. pacemaker, deep brain stimulation)
- ☐ Chemotherapy within last six months
- ☐ Diabetes
- ☐ Manual dexterity issues
- ☐ Stroke
- ☐ Radiation therapy to head/neck
- ☐ Compromised immune system
- ☐ High blood pressure
- ☐ Prescription blood thinners
- ☐ TMJ disorder

Allergies to any medications, plastics, etc.? ☐ Yes ☐ No If yes, what? _____

Current medications (If you have a list, we can make a copy):

_____

_____

Please list all major surgeries and illnesses (within the past 10 years):

_____

_____

Tinnitus *(ringing or buzzing in the ear)*

How long ago did you notice the tinnitus?
☐ Within the past 90 days ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ 10+ years
Do you remember anything specific about when you first began to hear the tinnitus? ☐ Yes ☐ No

If yes, describe: _____

_____

Where is the sound coming from? ☐ Right Ear ☐ Left Ear ☐ Both Ears ☐ Somewhere in head ☐ Other

Is the tinnitus: ☐ Constant ☐ Intermittent ☐ Pulsing ☐ Other (If other, describe): _____

Please describe what your tinnitus sounds like:

_____

_____

_____

_____

Was it a sudden or progressive onset? ☐ Sudden ☐ Progressive
Was it related to any medical issue? ☐ Yes ☐ No
Was it related to any environmental condition? ☐ Yes ☐ No
Does your tinnitus pulse with your heartbeat? ☐ Yes ☐ No
Is your tinnitus triggered by head or neck movement? ☐ Yes ☐ No
Is there anyone in your family who has/had tinnitus? ☐ Yes ☐ No
Have you consulted any other professional or tried any treatment for tinnitus? ☐ Yes ☐ No

Who did you see? _____

What were the results/recommendations? _____

_____

Does your tinnitus….
Make it difficult to fall asleep? ☐ Always ☐ Sometimes ☐ Never
Cause you to feel angry? ☐ Always ☐ Sometimes ☐ Never
Cause you to feel stressed? ☐ Always ☐ Sometimes ☐ Never
Cause you to feel sad? ☐ Always ☐ Sometimes ☐ Never
Make it difficult to concentrate while reading? ☐ Always ☐ Sometimes ☐ Never
Make it difficult to relax in a quiet room? ☐ Always ☐ Sometimes ☐ Never
Make it hard for you to hear other people? ☐ Always ☐ Sometimes ☐ Never
Make it difficult to focus your attention away from your tinnitus? ☐ Alway ☐ Sometimes ☐ Never

What percentage of the time are you aware of the tinnitus? _____%

How strong or loud was your tinnitus, on average, over the last month? "0" is no tinnitus and "10" is as loud as you can imagine.

Soft → 0 . . . . . 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . . 10 ← Loud

How much has tinnitus annoyed you, on average, over the last month"? "0" is not annoying at all and "10" is as annoying as you could imagine.

Not annoying → 0 . . . . . 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . . 10 ← Annoying

How much did tinnitus impact your life, over the last month? "0" is not at all and "10" is as much as you could imagine.

No impact → 0 . . . . . 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . . 10 ← Huge impact

Sound Tolerance *(How well you tolerate loud sounds)*

Do loud sounds (that seem normal to others) hurt your ears or bother you? ☐ Yes ☐ No

Does sound around you cause…
Your tinnitus to get loud or increase in any way? ☐ Always ☐ Sometimes ☐ Never
You to avoid going to certain places? ☐ Always ☐ Sometimes ☐ Never
You to feel irritated? ☐ Always ☐ Sometimes ☐ Never
You to use hearing protection (earplugs or earmuffs) specifically for your tinnitus? ☐ Yes ☐ No

Hearing

When was your last hearing exam? _____ Who conducted the hearing exam? _____

What were their recommendations? _____

How long ago did you notice a decline in hearing?
☐ Within the past 90 days ☐ 1-3 years ☐ 4-6 years ☐ 7-10 years ☐ 10+ years

Do you or have you ever used hearing aids? ☐ Yes ☐ No

Has anyone in your family suffered from hearing loss? ☐ Yes ☐ No If yes, whom? _____

Have you been exposed to loud noises (i.e. guns, music or tools)? ☐ Yes ☐ No If yes, what? _____

Do you have any of the following in your ear(s): ☐ Pain ☐ Drainage ☐ Plugged/Full feeling ☐ None of the above

Have you ever had ear surgery? ☐ Yes ☐ No If yes, which ear? _____ Type: _____

Do you often have significant cerumen (earwax) accumulation in your ear canal? ☐ Yes ☐ No

How would you rate your ability to understand what people are saying?

Difficult → 1 . . . . . 2 . . . . . 3 . . . . . 4 . . . . . 5 . . . . . 6 . . . . . 7 . . . . . 8 . . . . . 9 . . . . . 10 ← Easy

Check the situations below in which you would like to hear better

☐ Phone (mobile)	☐ Phone (landline)	☐ TV	☐ Work
☐ Religious services	☐ Restaurants	☐ Meetings	☐ Spouse
☐ Grandchildren	☐ Family gatherings	☐ Car	☐ Noisy places
☐ Outdoor activities (i.e. golfing, walking)		☐ Alerting devices (i.e. alarm clock, smoke detector)	

How much do you think a hearing system will improve your hearing?

No Help → 1 . . . . 2 . . . . 3 . . . . 4 . . . . 5 . . . . 6 . . . . 7 . . . . 8 . . . . 9 . . . . 10 ← Huge Improvement

If your test results indicate you need help, how motivated are you to use devices that can treat the tinnitus and/or hearing loss?

Not motivated → 1 . . . . 2 . . . . 3 . . . . 4 . . . . 5 . . . . 6 . . . . 7 . . . . 8 . . . . 9 . . . . 10 ← Very Motivated

What do you consider your main concern today? ☐ Hearing ☐ Tinnitus ☐ Sound tolerance

Have you experienced any stressful events within the past 12 months?

_____

_____

Additional Information:

_____

_____