



Name _____ Date _____

Address _____
Street City State Zip

Home Phone _____ Other Phone _____

Sex M F Birth Date _____ Email Address _____

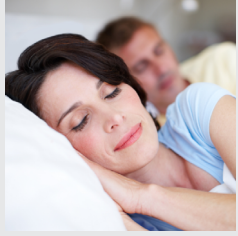
Primary Care Physician _____ Referred by _____

Occupation/Former Occupation _____

PLEASE ANSWER THE FOLLOWING GROUPS OF QUESTIONS

Have you ever?	
Had any noisy jobs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had any noisy hobbies or home activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Used solvents, thinners or alcohol based cleaners?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Taken any of the following medications: <i>Quinine, Quinidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No
Had any ear surgeries?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, describe:	
Do you?	
Have loose dentures, jaw pain or a grinding or clicking sensation in the jaw?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any pain in your ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any feelings of ear pressure or blockage?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have any feelings of dizziness?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Regularly take aspirin or disprin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Take any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please list:	
General Hearing Problems	
Do you have any difficulty hearing when there is background noise?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty understanding one-to-one conversations?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty hearing the TV?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have difficulty hearing on the telephone?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you find external sounds unpleasant or uncomfortable?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, please list:	
Do you wear ear protection/earplugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, how often and under what circumstances?	
Impact of Your Tinnitus	
Over the past week, what percentage of the time you were awake were you aware of your tinnitus? <i>(e.g. 100% aware - all the time, 25% aware - 1/4 of the time)</i>	%
What percentage of the time was it disturbing?	%

Rank the percentage (%) of time you are aware of the your tinnitus in the following situations (1-100%)



SLEEP
_____ %



QUIET ROOM
_____ %



SMALL CONVERSATION
_____ %



AT WORK
_____ %



OUTDOORS
_____ %



IN CROWDS
_____ %

In which ear does your tinnitus occur? Left Right Both Worse Right Worse Left Equal Effect

Is your tinnitus constant or intermittent? _____

Does your tinnitus fluctuate in intensity or loudness? _____

What makes your tinnitus worse? _____

What makes your tinnitus better? _____

Does your tinnitus prevent you from getting to sleep at night? Yes No

Do you find that exposure to moderately loud sounds makes your tinnitus worse? Yes No

Does your tinnitus affect your sleep? Yes No

How has tinnitus affected your work life? _____

How has tinnitus affected your home life? _____

How has tinnitus affected your social activities? _____

TINNITUS HISTORY

When did you first become aware of your tinnitus and what do you consider to have first started your tinnitus?

When did your tinnitus first become disturbing? _____

Who have you consulted about your tinnitus? _____

What have you been told about your tinnitus? _____

What treatments have you tried for your tinnitus? None TRT Hearing Device Counseling Masker

Music Therapy Other, please comment _____

How successful did you find these treatments? _____

Please rank the auditory problems you experience: Not very troublesome (1) to very troublesome (10)

_____ Hearing _____ Tinnitus _____ Sensitivity to loud sounds