

Tinnitus Handicap Inventory (THI)

Patient Name _____ Date ____/____/____
First Last MI mm dd yyyy

Instructions: To fill out the questionnaire, check off the box for “Yes,” “No” or “Sometimes” next to each question.

F1	Because of your tinnitus is it difficult for you to concentrate?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F2	Does the loudness of your tinnitus make it difficult for you to hear people?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F3	Does your tinnitus make you angry?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F4	Does your tinnitus make you confused?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
C5	Because of your tinnitus are you desperate?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
E6	Do you complain a great deal about your tinnitus?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F7	Because of your tinnitus do you have trouble falling to sleep at night?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
C8	Do you feel as though you cannot escape your tinnitus?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F9	Does your tinnitus interfere with your ability to enjoy social activities? (such as going out to dinner, to the cinema?)	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
E10	Because of your tinnitus do you feel frustrated?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
C11	Because of your tinnitus do you feel that you have a terrible disease?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F12	Does your tinnitus make it difficult to enjoy life?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F13	Does your tinnitus interfere with your job or household responsibilities?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F14	Because of your tinnitus do you find that you are often irritable?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F15	Because of your tinnitus is it difficult for you to read?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
E16	Does your tinnitus make you upset?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
E17	Do you feel that your tinnitus has placed stress on your relationships with members of your family and friends?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F18	Do you find it difficult to focus your attention away from your tinnitus and on to other things?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
C19	Do you feel that you have no control over your tinnitus?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F20	Because of your tinnitus do you often feel tired?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
E21	Because of your tinnitus do you feel depressed?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
E22	Does your tinnitus make you feel anxious?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
C23	Do you feel you can no longer cope with your tinnitus?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
F24	Does your tinnitus get worse when you are under stress?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No
E25	Does your tinnitus make you feel insecure?	<input type="checkbox"/> Yes <input type="checkbox"/> Sometimes <input type="checkbox"/> No

To score the patient’s questionnaire, count the number of “Yes” and “Sometimes” answers and then calculate the total points.

$$\# \text{ of "Yes"} \quad \text{_____} \times 4 = \boxed{} + \# \text{ of "Sometimes"} \quad \text{_____} \times 2 = \boxed{} = \text{TOTAL POINTS THI SCORE } \boxed{}$$

Newman, C. W., Jacobson, G. P., & Spitzer, J. B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg, 122, 143-148.

McCombe, A., Bagueley, D., Coles, R., McKenna, L., McKinney, C. & Windle-Taylor, P. (2001). Guidelines for the grading of tinnitus severity: The results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999. Clin Otolaryngol, 26, 388-393.