

Tinnitus Intake Form

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

Address _____
Street City State Zip

Home Phone _____ Other Phone _____


Sex M F Birth Date _____ Email Address _____

Primary Care Physician _____ Clinic _____

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 medication: <i>Quininne, Quindidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin</i> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you | |
| Have loose dentures, jaw pain or grinding or clicking sensation in the jaw? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Regularly take aspirin or dispirin? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have any feelings of ear pressure or blockage? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| General hearing problems | |
| Do you have any difficulties hearing when there is background noise? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have difficulties understanding one-to-one conversations? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have difficulties hearing the TV? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Do you have difficulties 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 / ear plugs? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If so, how often and under what circumstances? | |
| Affect 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

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 exposure to moderately loud sounds make 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