Rametta Audiology &
Hearing Aid Center

416 4th Avenue.Suite 100
Tarentum, PA 15084
724-224-6811

Tinnitus History Questionnaire

Name: _____

Date: _____

Nature of your Tinnitus

How does your tinnitus sound? _____

_____

Usual site of your tinnitus?

Left =Right	Left worse than Right	Right worse than Left	Central

(Please circle the correct site)

Is your tinnitus constant or intermittent?	
Does your tinnitus fluctuate in intensity or loudness?	
What makes your tinnitus worse?	
What makes your tinnitus better?	

Tinnitus History

When did you first become aware of your tinnitus?	
When did your tinnitus first become disturbing?	
Under what circumstances did your tinnitus start?	
What do you consider to have started your tinnitus?	
Who have you consulted about your tinnitus?	
What have previous professionals said your tinnitus is due to?	
What treatments have you tried for your tinnitus?	❒None ❒TRT ❒ Hearing Aid ❒Counseling ❒Masker ❒Music Therapy ❒Other please comment
How successful did you find these treatments?	

Have you ever:		Details/Comments
Been exposed to gunfire or explosion?	❒Yes ❒ No	
Attended loud events (e.g. music concerts or clubs)?	❒Yes ❒ No	
Had any noisy jobs?	❒Yes ❒ No	
Had any noisy hobbies or home activities?	❒Yes ❒ No	
Had any head injuries or concussion?	❒Yes ❒ No	
Had any operations involving your ear or head?	❒Yes ❒ No	
Taken any of the following medications: *Quininne, Quindidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin*	❒Yes ❒ No	
Used solvents, thinners, or alcohol based cleaners?	❒Yes ❒ No	
Do you		
Have loose dentures, jaw pain or grinding or clicking sensation in the jaw?	❒Yes ❒ No	
Regularly take aspirin or dispirin?	❒Yes ❒ No	
Have any feelings of ear pressure or blockage?	❒Yes ❒ No	
Do you find exposure to moderately loud sounds make your tinnitus worse?	❒Yes ❒ No	
General Hearing Problems		
Do you have any difficulties hearing when there is background noise?	❒Yes ❒ No	
Do you have difficulties understanding in one-to-one conversations?	❒Yes ❒ No	
Do you have difficulties hearing the TV?	❒Yes ❒ No	
Do you have difficulties hearing on the telephone?	❒Yes ❒ No	
Do you have any dizziness or balance problems?	❒Yes ❒ No	
Do you find external sounds unpleasant or uncomfortable?	❒Yes ❒ No	
Do you dislike certain external sounds?	❒Yes ❒ No	
Do you wear ear protection/ear plugs?	❒Yes ❒ No	

Please rank the auditory problems you experience: Most troublesome (1) to least troublesome (3)

_____ Hearing _____ Tinnitus _____Sensitivity to loud sounds

Affect of your Tinnitus

		Details/Comments
Over the past week, what percentage of the time you were awake were you aware of your tinnitus? (e.g. 100% aware – all the time, 25% aware ¼ of the time)	%	
What percentage of the time was it disturbing	%	
Does your tinnitus prevent you from getting to sleep at night?	❒Yes ❒ No	
How many times per night did you awake in the last week?		
How has tinnitus affected your work life?		
How has tinnitus affected your home life?		
How has tinnitus affected your social activities?		

General Health

	Details/Comments
What is your general health like?	
Are you taking any medications? If yes, please specify	

Compensation

Are you currently pursing any form of compensation, sickness benefit, DVA, motor vehicle accident claim or any other legal action in relations to your tinnitus? ❒Yes ❒ No

Medical Contact Details:

Name and address/clinic of your GP: _____

Name and address/clinic of your ENT: _____

I give consent to release results to my GP and /or ENT: ❒Yes ❒ No _____

Sign Date

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?

_____

_____