

TINNITUS QUESTIONNAIRE

NAME: _____

Please indicate if you experience the following by putting an "X" in either the first circle for YES or the second circle for NO.

I. QUESTIONS ABOUT HEARING:

YES NO

- 1. Do you have a hearing problem?
- 2. How long have you had the hearing problem?
- 3. Do you know what caused your hearing problem?
- 4. Have you ever been exposed to very loud noise?

Describe: _____

II. QUESTIONS ABOUT TINNITUS (hearing noises in your ears/head)

YES NO

- 1. When did you first notice your tinnitus?
- 2. My tinnitus is:
 - Constant Intermittent
- 3. My tinnitus is in my:
 - Right Ear Left Ear Head
- 4. Does your tinnitus pulse?
- If so, is it in time with your heartbeat?
- 5. When did you first notice your tinnitus? _____
- 6. Did you have any illness, accident, head injury, medication changes, or another occurrence that coincided with the onset of your tinnitus?

Describe: _____

- 7. Do you have balance or dizziness problems?

Describe: _____

8. Have you discovered anything that worsens your tinnitus even temporarily? For example:

- Loud noise exposure Medication
- Body/head position Teeth grinding
- Jaw clenching Altitude Change
- Physical exertion Other: _____

- 9. Does your tinnitus interfere with your ability to concentrate on a task?
- 10. Does your tinnitus interfere with **getting** to sleep?
- 11. Does your tinnitus interfere with **staying** asleep?
- 12. Have you given up any activities you enjoy because of your tinnitus?
- 13. Has your tinnitus had any effect on your job, or job performance?
- 14. Would you describe the overall effect of your tinnitus on your lifestyle as?
 - Profound Severe
 - Moderate Mild
- 15. What things have you tried, so far, to help you cope with your tinnitus? _____
- 16. Are you willing to work hard, and commit significant time, in order to better improve your ability to cope with your tinnitus?
- 17. Is there any other information concerning your tinnitus and/or coping that you feel might be helpful?