

## 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

\_\_\_\_\_ %



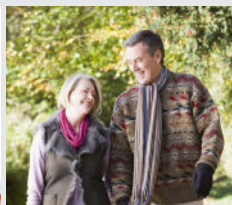
SMALL CONVERSATION

\_\_\_\_\_ %



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