



EAR INSTITUTE OF TEXAS



Tinnitus Questionnaire

Tinnitus is the medical term for ringing, roaring, or other noises that a person hears in the ear(s). When evaluating symptoms of tinnitus, patient history and description of the symptoms is extremely important in making a correct diagnosis. Please mark all answers that apply and fill in the appropriate blanks.

YES NO

Location:

___ ___ The sound is heard in which ear?
___ right ___ left ___ both

Quality:

Rate the severity of how the tinnitus is bothersome to your lifestyle on a scale of 1-10

Right ___/10 Left ___/10

___ ___ Does it affect your ability to sleep?

___ ___ Does it affect your ability to concentrate?

What best describes your tinnitus?

Frequency/Pitch

___ Ringing

___ High frequency

___ Rushing, roaring, or seashell noise

___ Mid frequency

___ Buzzing

___ Low frequency

___ Whistling

___ Pulsatile : ___ regular with heartbeat

___ erratic rhythm

___ Popping

___ Other (please describe) _____

Duration, timing, and context:

How long ago did you first begin experiencing tinnitus? _____

___ ___ Is the tinnitus constant?

___ ___ Is the tinnitus recurrent?

If recurrent, how long do episodes last? (provide range): _____ (circle one) seconds/minutes/days

How often do the episodes occur? (provide range) _____ per day/week/month

Modifying factors:

___ ___ Is the tinnitus triggered or made worse by:

___ stress/anxiety ___ loud noise ___ dietary factors (i.e. caffeine or salt) ___ positions

Other (please explain) _____?

___ ___ Is it more prominent in a quiet environment?

What makes the tinnitus less noticeable _____?

___ ___ Have you been exposed to loud noise? If so what: _____?

___ ___ Have you started new medications when the tinnitus began (especially intravenous antibiotics or chemotherapy)? If so what medication _____?

Associated signs and symptoms (check where appropriate):

___ Headache ___ Ear pain ___ Dizziness ___ Allergies ___ Ear infections

___ Visual changes ___ Hearing loss ___ Feeling of pressure in the ears

Other (please explain) _____

Previous evaluation and treatment:

___ ___ Have you seen a physician for the tinnitus? If so, name _____

What prior tests have you had: ___ Hearing Test ___ ABR ___ MRI?

What prior treatments have you tried _____?

Patient Name _____ Patient Signature _____