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Patient History: Tinnitus

Patient: _____ DOB: _____ Date: _____

If you have ear noises (tinnitus), please complete the following history form.

Yes / No

_____ _____ 1. Are your noises localized?
____ Right ear ____ Head
____ Left ear ____ Cannot localize
____ Both ears ____ If both, which ear is worse? Right / Left / Neither

_____ _____ 2. How long have you had head noises? (Indicate which ear, and for how long)

Right / Left / Both

How long have they been bothersome?
____ Days ____ Months
____ Weeks ____ Years

_____ _____ 3. Was there a particular incident (cold, explosion, etc.) that seems to have started your noises? If yes, please describe:

_____ _____ 4. Has the noise changed since it first appeared?
If yes, please describe:

_____ _____ 5. Is it constantly present?

_____ _____ 6. Is it episodic (comes and goes)?
If yes, during what percentage of the time is it usually present during waking hours?

_____ _____ 7. If it is episodic, are you completely free of noise between attacks?

_____ _____ 8. Recently, have attacks occurred more frequently?

_____ _____ 9. Recently, have attacks occurred less frequently?

Yes / No

_____ _____ 10. Are the noises more apt to occur at a particular time of the day?
If yes, when?:
____ Morning ____ Daytime
____ Evening ____ Night ____ None

_____ _____ 11. Is there any activity that brings on the noises or makes them worse?
If yes, describe:

_____ _____ 12. Are the noises worse when you are under stress?

_____ _____ 13. Are the noises worse when you are tired?

_____ _____ 14. Are there any foods or substances to which you are exposed that aggravate the noises?
If yes, please check the following that apply:
____ Alcohol ____ Coffee
____ Cigarettes ____ Chocolate
____ Excessive salt ____ Other, describe:

_____ _____ 15. Are the noises worse during any season?
If yes, when: ____ Summer ____ Fall ____ Winter ____ Spring

_____ _____ 16. Is there anything you can do to decrease the noises or make them go away?
If yes, describe:

_____ _____ 17. Are there any activities or sounds that make the noises less disturbing?
If yes, describe:

_____ _____ 18. Does the noise sound the same in both ears?
Please characterize the noise.
____ Ringing ____ Heartbeat
____ Whistling ____ Bells
____ Buzzing ____ Hissing
____ Sea-shell-like ____ Voices
(ocean roar)

_____ _____ 19. What medications or treatments for the noises have you tried?
Please list:

_____ _____ 20. Have any of them helped?
Which?

Yes / No

_____ _____ 21. To which of the following would you compare the loudness of your noise?

____ A soft whisper ____ A diesel truck motor
____ An electric fan ____ A jet taking off

_____ _____ 22. Is the loudness fairly constant?

_____ _____ 23. Does it vary slightly from day-to-day?

_____ _____ 24. Does it vary widely from day-to-day?

_____ _____ 25. Please rate the severity of the noises on a scale from 1 – 10.
(Please check)

____ Mild (1, 2) - aware of it when you think about it
____ Moderate (3, 4, 5) - aware of it frequently, but able to ignore most of the time; occasionally interferes with falling asleep
____ Severe (6, 7, 8) - aware of it all the time, very disturbing; often interferes with activities, communication, etc.
____ Very Severe (9, 10) - aware of it all the time, interferes with daily activities, communication and sleep; has changed your behavior

_____ _____ 26. Do you think other people should be able to hear the noises?

_____ _____ 27. Do the noises sound as if they are coming from:

____ Inside your head ____ Outside your head

_____ _____ 28. Are your head noises ever voices?
If yes, what do they say to you?

_____ _____ 29. Do you have a feeling of fullness in your ears?
If yes, does it fluctuate with the noises?

_____ _____ 30. Has anyone else in your family had tinnitus?

_____ _____ 31. Do you have a hearing loss?
IMPORTANT: If you answered yes to question 31, ask for the "Hearing Loss" History form.

_____ _____ 32. Do you have dizziness?
IMPORTANT: If you answered yes to question 32, ask for the "Dizziness" History Form.