

MEDICAL AUDIOLOGY SERVICES

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TINNITUS HISTORY QUESTIONNAIRE (THQ)

NATURE OF THE TINNITUS					
How does the tinnitus sound?					
Usual site of the tinnitus (please circle)	Lt	Rt	Left worse than right	Right worse than left	Central
Is the tinnitus constant or intermittent?					
Does the tinnitus fluctuate in intensity?					
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 the tinnitus start?					
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?	<input type="checkbox"/> None <input type="checkbox"/> Hearing Aid <input type="checkbox"/> Masker <input type="checkbox"/> Counseling <input type="checkbox"/> Music therapy <input type="checkbox"/> Other- please comment:				
How successful did you find these treatments?					
HAVE YOU EVER					
Been exposed to gunfire or explosion?	Y/N Details:				
Attended loud events e.g. music concerts or clubs?	Y/N Details:				
Had any noisy jobs?	Y/N Details:				

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HAVE YOU EVER (cont'd)	
Had any noisy hobbies or home activities?	Y/N Details:
Had any head injuries or concussion?	Y/N Details:
Had any operations involving your ear or head?	Y/N Details:
Taken any of the following medications? Quinine, Quinidine, Streptomycin, Kantamycin, Dihydrostreptomycin, Neomycin.	Y/N Details:
Used solvents: thinners or alcohol based cleaners?	Y/N Details:
Do you have loose dentures, jaw pain or grinding and clicking sensations in the jaw?	Y/N Details:
Do you regularly take Aspirin or Dispirin?	Y/N Details:
Have any feelings of ear pressure or blockage?	Y/N Details:
Do you find exposure to moderately loud sounds make your tinnitus worse?	Y/N Details:
What is your current occupation?	
GENERAL HEARING PROBLEMS	
Do you have any difficulties in hearing when there is background noise?	Y/N Details:
Do you have difficulties understanding in one to one conversations?	Y/N Details:
Do you have difficulties hearing the TV?	Y/N Details:
Do you have difficulties hearing on the telephone?	Y/N Details:
Do you have any dizziness or balance problems?	Y/N Details:
Do you find external sounds unpleasant or uncomfortable?	Y/N Details:
Do you dislike certain external sounds?	Y/N Details:
Do you wear ear protection/ear plugs?	Y/N Details:

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GENERAL HEARING PROBLEMS (cont'd)

Please score the auditory problems you experience from most troublesome (1) to least troublesome (3)		Hearing loss
		Tinnitus
		Sensitivity to loud sounds

EFFECT OF TINNITUS

Over the past week, what % of the time were you awake and aware of the tinnitus (eg. 100% aware all the time, ¼ of the time aware etc)	_____ % Details:
What percentage of the time is your tinnitus disturbing?	_____ % Details:
Does your tinnitus prevent you from getting to sleep at night?	Y/N Details:
How many times per night did it wake you in the last week?	
How has tinnitus affected your work life?	
How has tinnitus affected your home life?	
How has tinnitus affected your social life activities?	

GENERAL HEALTH

What is your general health like?	
Are you taking any medications?	Specify:

Compensation: Are you currently pursuing any form of compensation, sickness benefit, DVA, motor vehicle accident claim, or any other legal action in relation to your tinnitus Yes No

Name of ENT Specialist: _____

Name: _____ Signed: _____ Date: _____