



Tinnitus Questionnaire

Name: _____ Date: _____

**Tinnitus is the abnormal sensation of sound in the head or ears.
Describe your tinnitus.**

1. Where do you have tinnitus?

- Both ears equally Both ears but not equally: _____
 In head Right ear only Left ear only

2. How long have you had tinnitus?

- Less than 1 year 1-2 years Over 2 years

3. Was there a particular incident you think caused the tinnitus? _____

4. How much time passed between that incident and when your tinnitus began? _____

5. Has your tinnitus changed since it first started? Yes No

Describe: _____

6. Does your tinnitus remain constant or fluctuate?

- Remains fairly constant Fluctuates hourly or daily

7. If it fluctuates, how often and to what extent? _____

8. Rate the severity of your tinnitus:

- 1 (mild) 2 3 4 5 6 7 8 9 10 (severe)

9. Are there times when your tinnitus is more likely to occur?

- Always
- | | |
|--|---|
| <input type="checkbox"/> During the day | <input type="checkbox"/> At night |
| <input type="checkbox"/> When stressed/tense/nervous | <input type="checkbox"/> When tired |
| <input type="checkbox"/> When relaxed | <input type="checkbox"/> After drinking alcohol |
| <input type="checkbox"/> After smoking | <input type="checkbox"/> During and/or after exercise |
| <input type="checkbox"/> After loud noise exposure | <input type="checkbox"/> After consuming caffeine |
- During allergies: _____
- After taking medication: _____
- After eating: _____
- Other: _____
-

10. Estimate the pitch of your tinnitus:

- 1 (low) 2 3 4 5 6 7 8 9 10 (high)

11. Is the loudness of your tinnitus steady or does it pulsate?

- Steady Pulsates

12. Describe the sound of your tinnitus:

- | | | |
|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Hissing | <input type="checkbox"/> Chirping | <input type="checkbox"/> Beating/Pulsating/Pounding |
| <input type="checkbox"/> Whistling | <input type="checkbox"/> Ringing | <input type="checkbox"/> Clanging <input type="checkbox"/> Roaring |
| <input type="checkbox"/> Voices | <input type="checkbox"/> Other: _____ | |
-
-

13. How often do you smoke?

- 0-1 time per day 2-5 times per day Over 5 times per day

14. How often do you drink caffeinated coffee, tea or soda?

- 0-1 time per day 2-3 times per day Over 3 times per day

15. Have you ever had a head injury?

- Yes No

Describe: _____

16. Have you been exposed to loud sounds (loud enough that you have to shout for someone to hear you at arm's length)? Yes No

Describe: _____

17. Do you wear ear protection during loud sounds? Yes No

18. Does anything give you relief from your tinnitus? Yes No

Describe: _____

19. Do you have a feeling of fullness in your ears? Yes No
Does the feeling change with your tinnitus? Yes No

20. Do you have dizziness? Yes No
Does the dizziness change with your tinnitus? Yes No

21. Are you currently taking any prescription or over-the counter medications? Describe all your medications including aspirin and aspirin-containing products: _____

22. Are you currently taking any vitamins, minerals or herbal supplements? Describe: _____

23. Describe any additional information you think EAR Audiology should know: _____

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