TINNITUS HANDICAP INVENTORY

Patient Name: ______________________________ Date: ____________

INSTRUCTIONS: The purpose of this questionnaire is to identify difficulties that you may be experiencing because of your tinnitus. Please answer every question. Please do not skip any questions.

1.	Because of your tinnitus, is it difficult for you to concentrate?	Yes	Sometimes	No
2.	Does the loudness of your tinnitus make it difficult for you to hear people?	Yes	Sometimes	No
3.	Does your tinnitus make you angry?	Yes	Sometimes	No
4.	Does your tinnitus make you feel confused?	Yes	Sometimes	No
5.	Because of your tinnitus, do you feel desperate?	Yes	Sometimes	No
6.	Do you complain a great deal about your tinnitus?	Yes	Sometimes	No
7.	Because of your tinnitus, do you have trouble falling to sleep at night?	Yes	Sometimes	No
8.	Do you feel as though you cannot escape your tinnitus?	Yes	Sometimes	No
9.	Does your tinnitus interfere with your ability to enjoy your social activities (such as going out to dinner, to the movies)?	Yes	Sometimes	No
10.	Because of your tinnitus, do you feel frustrated?	Yes	Sometimes	No
11.	Because of your tinnitus, do you feel that you have a terrible disease?	Yes	Sometimes	No
12.	Does your tinnitus make it difficult for you to enjoy life?	Yes	Sometimes	No
13.	Does your tinnitus interfere with your job or household responsibilities?	Yes	Sometimes	No
14.	Because of your tinnitus, do you find that you are often irritable?	Yes	Sometimes	No
15.	Because of your tinnitus, is it difficult for you to read?	Yes	Sometimes	No
16.	Does your tinnitus make you upset?	Yes	Sometimes	No
17.	Do you feel that your tinnitus problem has placed stress on your relationships with members of your family and friends?	Yes	Sometimes	No
18.	Do you find it difficult to focus your attention away from your tinnitus and on other things?	Yes	Sometimes	No
19.	Do you feel that you have no control over your tinnitus?	Yes	Sometimes	No
20.	Because of your tinnitus, do you often feel tired?	Yes	Sometimes	No
21.	Because of your tinnitus, do you feel depressed?	Yes	Sometimes	No
22.	Does your tinnitus make you feel anxious?	Yes	Sometimes	No
23.	Do you feel that you can no longer cope with your tinnitus?	Yes	Sometimes	No
24.	Does your tinnitus get worse when you are under stress?	Yes	Sometimes	No
25.	Does your tinnitus make you feel insecure?	Yes	Sometimes	No

FOR CLINICIAN USE ONLY

Total Per Column						
	x4		x2		x0	
Total Score		+		+		=

Newman, C.W., Jacobson, G.P., Spitzer, J.B. (1996). Development of the Tinnitus Handicap Inventory. Arch Otolaryngol Head Neck Surg. 122, 143-8

To interpret the score please refer to the Tinnitus Handicap Severity Scale shown on the reverse side.

Tinnitus History Questionnaire

Name:____________________

DOB: ________ Date Completed:__________

Nature of the Tinnitus

How does the tinnitus sound? ____________________

Usual site of the tinnitus? (circle) Left = Right | Left worse than Right | Right worse than Left | Central

Is the tinnitus constant or intermittent? ____________________

Does the tinnitus fluctuate in intensity or loudness? ____________________

What makes your tinnitus worse? ____________________

What makes your tinnitus better? ____________________

Tinnitus History

When did you first become <u>aware</u> of your tinnitus? ____________________

When did your tinnitus first become <u>disturbing</u>? ____________________

Under what circumstances did the tinnitus start? ____________________

What do you consider to have started the tinnitus? ____________________

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?

- ☐ None
- ☐ Hearing Aid
- ☐ Masker
- ☐ TRT
- ☐ Counselling
- ☐ Music Therapy
- ☐ Other - please comment ____________________

How successful did you find these treatments? ____________________

Tinnitus History Questionnaire

Name________________
Date Completed________________

Have you ever:	Y/N	Details/Comments
Been exposed to gunfire or explosion? How often were you exposed? Did you wear hearing protection?		
Attended loud events? (e.g., concerts, clubs)		
Had any noisy jobs?		
Had any noisy hobbies or home activities?		
Had any head injuries or concussion?		
Had any operations involving your ear or head?		
Used solvents, thinners or alcohol based cleaners?		
Taken any of the following medications: Quinine, Quinidine, Streptomycin, Kanamycin, Dihydrostreptomycin, Neomycin		

Do you:	Y/N	Details/Comments
Have loose dentures, jaw pain or grinding and clicking sensations in the jaw?		
Regularly take aspirin or dispirin?		
Have any feelings of ear pressure or blockage?		
Do you find exposure to moderately loud sounds make your tinnitus worse?		
What is your current occupation?		

General Hearing Problems

	Y/N	Details/Comments
Do you have any difficulties hearing when there is background noise?		
Do you have difficulties understanding in one-to-one conversations?		
Do you have difficulties hearing the TV?		
Do you have difficulties hearing on the telephone?		
Do you have any dizziness or balance problems?		
Do you find external sounds unpleasant or uncomfortable?		
Do you dislike certain external sounds?		
Do you wear ear protection / ear plugs?		

Tinnitus History Questionnaire

Name____________________
Date Completed____________________

Please rank the auditory problems you experience from most troublesome (1) to least troublesome (3)

	Hearing Loss
	Tinnitus
	Sensitivity to Loud Sounds

Effect of the Tinnitus

	Y/N	Details/Comments
Does your tinnitus prevent you from getting to sleep at night?		

How many times per night did you awake in the last week? ____________________

How has tinnitus affected your work life? ____________________

How has tinnitus affected your home life? ____________________

How has tinnitus affected your social activities? ____________________

General Health

What is your general health like? ____________________

Are you taking any medications?
If yes, please specify. ____________________

____

Compensation

	Y/N	Details/Comments
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?		

Medical Contact Details

Name and Address of GP ____________________

Name and Address of ENT ____________________

I give consent to release results to my GP /ENT Signed: ____________________

Is there anything else you would like to add that might be relevant to understanding what caused your tinnitus?