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Tinnitus Description and History

Name: _____ Birthdate: _____

1. When did you become aware of having tinnitus? _____
2. Did you become aware of your tinnitus suddenly or gradually? _____
3. Before that did you experience any episodes of temporary or milder tinnitus? _____
 If yes, was it after exposure to loud sound?____, associated with colds, flu, or an allergy problem_____, or any other event_____.
4. How long have you had tinnitus as a significant problem? _____
5. Were illness, accident, or other special circumstances associated with the onset of your tinnitus? _____ Please explain: _____
6. Does your tinnitus consist of one sound or more than one sound? _____
7. In the list below, please check the sound(s) that most closely resembles your tinnitus:

<input type="checkbox"/> Ringing	<input type="checkbox"/> Hissing	<input type="checkbox"/> Sizzling	<input type="checkbox"/> Pulsating
<input type="checkbox"/> Clear tone	<input type="checkbox"/> Buzzing	<input type="checkbox"/> Transformer	<input type="checkbox"/> Pounding
<input type="checkbox"/> Many tones	<input type="checkbox"/> Hum	<input type="checkbox"/> High tension wire	<input type="checkbox"/> Ocean roar
<input type="checkbox"/> Whistle	<input type="checkbox"/> Music	<input type="checkbox"/> Crickets, insects	<input type="checkbox"/> Clicking

Other, please describe _____

Has your tinnitus sounded about the same in terms of the type of sound since it first started, or has the type of sound changed? _____ Describe the change if any _____

8. If you hear more than one sound, which sound is predominant or most bothersome?

9. Where does your predominant tinnitus sound appear to be coming from? _____
 If in more than one location, where is it worst _____
10. If you do hear other tinnitus sounds besides the predominant one, please describe the type and location of the sound(s) _____
11. Do you hear your predominant tinnitus sound constantly _____ or only part of the time? What percentage of time do you hear it? _____.



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Since your tinnitus started, has the percentage of time you hear it increased or decreased? _____

12. Since your tinnitus started, has the location changed? _____ If yes, please describe the change _____
13. Since your tinnitus started, has the loudness changed? _____ If yes, please describe the change _____
14. Does the loudness of your tinnitus fluctuate? _____ If yes, is the change barely noticeable, moderate, very marked, or variable in size? _____. If yes, how often do the fluctuations occur? _____.

15. On the scale below, please indicate the loudness of your usual tinnitus:

0 1 2 3 4 5 6 7 8 9 10

Very Quiet

Moderate

Very Loud

16. Have you noticed changes in tinnitus loudness caused by any of the following? Check all that apply and indicate whether they make tinnitus louder or softer.

	Louder	Softer
Tobacco Use		
Marijuana		
Alcoholic Beverages		
Caffeine (coffee, tea, cola, etc.)		
Aspirin		
Tylenol, or other pain killer		

17. Have you noticed changes in tinnitus loudness caused by any of the following? Check all that apply and indicate whether they make tinnitus louder or softer.

	Louder	Softer
Noise Exposure		
Stress or Fatigue		
Colds, sinus, hayfever, allergies		

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	Coughing or sneezing		
	Moving jaw, clenching teeth		
	Changes in altitude		
	Alterations in body position		

18. Is there anything else that you have noticed that causes change in your tinnitus? _____

19. Does your tinnitus interfere with sleep? _____ No _____ Yes, Sometimes _____ Often. If yes, do you have trouble _____ getting to sleep, _____ staying asleep _____ Other. If yes, is the problem _____ mild, _____ moderate, _____ severe?

20. Do you feel that your tinnitus

	No	Sometimes	Yes
Makes you feel irritable or nervous			
Makes you feel tired or ill			
Makes it difficult to relax			
Makes it uncomfortable to be in quiet			
Makes it difficult to concentrate			
Makes it harder to interact pleasantly with others			

21. Are there any other problems your tinnitus has caused you? _____

22. Have you changed jobs because of tinnitus? _____ If yes, please explain _____

23. Have you made other significant changes in your lifestyle because of tinnitus? _____ If yes please explain _____

24. How much of an effort is it for you to ignore your tinnitus when it is present?

	Can easily ignore it
	Can ignore it with some effort
	It takes considerable effort to ignore it
	Can never ignore it



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25. How much discomfort do you usually experience when your tinnitus is present?

No discomfort	Moderate discomfort
Mild discomfort	A great deal of discomfort

26. How much interference does tinnitus cause you for the following activities?

	None	Slight	Moderate	A great deal
Work Activities				
Social Activities				
Overall Enjoyment				

27. Have you previously sought medical help for your tinnitus? _____ If yes, where and when? _____

28. Have you previously tried any of the following types of treatment for tinnitus?

	Describe	Dates	Amount of relief
	Biofeedback		
	Drug therapy		
	Masking		
	Hypnosis or Acupuncture		
	Other		



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Tinnitus Handicap Inventory

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

Reference: McCombe, A., Bagueley, D., Coles, R., McKenna, L., McKinney, C. & Windle-Taylor, P., (2001). Guidelines for the grading of tinnitus severity: the results of a working group commissioned by the British Association of Otolaryngologists, Head and Neck Surgeons, 1999, Clin. Otolaryngol 26, 388-393.

Case History - Adult

Patient Name: _____ Birthdate _____

1) How can we help you? _____

2) Are you having any pain, fullness, or drainage in or around your ears? If so, which ear?

If you have:	Ear Pain	Ear Fullness	Ear Drainage	Tinnitus
Check box:				
Indicate R, L, or both ears:				
How long:				

Please indicate details _____

3) Are you having any dizziness, light-headedness, or loss of balance? _____

If yes, describe _____



Worst

Best

4) How would you rate your overall hearing and understanding ability?

5) Using this 1-10 scale, how well do you you hear on the telephone? _____

6) Which ear do you use on the telephone? R or L Circle: habit or hear better

7) Have you ever had your ears operated on? _____ If yes, when? _____,
 by whom? _____ describe: _____

8) Have you had any surgery for which you had to have a general anesthetic during the past 5 years? _____



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9) Please name all the medications, vitamins, supplements, etc, you take for anything (it does not matter where you procured it). ___check if list provided. _____

10) Have you ever had any sudden changes in your hearing? _____

If yes, when? _____

Treatment? _____

11) Have you ever been exposed to extremely loud noise? _____

Describe _____ For how long? _____

12) Is there anyone in your family who has a serious problem with their hearing? _____

Describe _____

13) Have you ever had any problems with your heart or with your blood pressure? _____

14) Have you had a stroke? _____

15) Are you diabetic? _____ Do you have diabetes in your family? _____

16) Have you seen an Ear, Nose, and Throat specialist (ENT)? _____ Who? _____

When? _____ For? _____

Treatment? _____

17) When was the last time you had your hearing tested? _____

Results and recommendations? _____

18) Do you feel you need hearing aids? _____

19) Have you ever worn hearing aids? _____ Type? _____

If yes, what would you like to improve? _____

Patient Name: _____ Birthdate _____

20) List the top three situations you would most like to hear better:

1 _____

2 _____

3 _____

21) What is your most important consideration regarding hearing aids. Please rank 1 as most important, 4 as least important:

____ Hearing aid size and appearance

____ Improved ability to understand speech in quiet situations

____ Improved ability to understand speech in noisy situations such as restaurants

____ Cost of Hearing Instruments

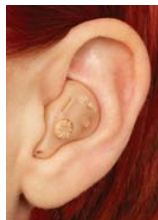
22) Do you think you prefer hearing devices that are:

____ totally automatic so that you do not have to make any adjustments to them

____ allow you to adjust the volume and change the listening programs as you see fit

____ no preference or not sure

23) Look at the pictures of hearing instrument styles. Please place an X on the picture of the styles you would **NOT** be willing to use. Dr. Holmes will discuss with you if your choices are appropriate for you given your hearing profile and physical shape of your ear.





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Patient Name: _____ Birthdate _____

24) Is there anything else you would like to make us aware of? _____
